STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175520	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VICTORIA FALLS	224 E CENTRAL ANDOVER, KS 67002

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0567 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to manage his or her financial affairs.** The facility reported a census of 64 residents and identified 36 residents with a personal funds account handled by the facility. Based on interview and record review the facility failed to provide 14 Residents (R)59, R73, R72, R25, R39, R32, R3, R15, R70, R10, R16, R60, R30, and R68, with interest based on actual earnings or end of quarter balances, during the year of 2019. Additionally, the facility allowed three Residents, R1, R44, and R1, to have a negative balance in the pooled residents' account with the other residents. Findings included: - Review of the facility's Trust Transaction History, dated 06/01/2020 through 07/31/2020, documented the facility had 36 residents with trust accounts which included 14 residents that were not credited with interest for the year of 2019, until 07/31/2020. The residents and interest payments documented on 07/31/2020 were as follows: 1. Resident (R) 59, in the amount of $0.20 2. R73, in the amount of $29.52 3. R72, in the amount of $1.56 4. R25, in the amount of $2.29 5. R39, in the amount of $47.85 6. R32, in the amount of $2.60 7. R3, in the amount of $2.43 8. R15, in the amount of $0.49 9. R70, in the amount of $39.17 10. R10, in the amount of $1.56 11. R16, in the amount of $.45 12. R60, in the amount of $1.56 13. R30, in the amount of $26.26 14. R68, in the amount of $0.76 Review of the facility's Trust Transaction History, dated 06/01/2020 through 07/31/2020, documented the facility had 36 residents with trust accounts which included three residents with current negative balances in the residents' trust account, which equates to a loan from the other account holders (residents) in the pooled account and resulted in an inequitable distribution of the interest. Those accounts included: 1. R1, negative balance of (-$16.00). 2. R44, negative balance of (-$2.68). 3. R01, negative balance of (- $5.00). On 08/03/20 at 12:37 PM, Administrative Staff A reported that quarterly statements were sent out to the residents. Balances of $50.00 dollars or more were in a pooled interest-bearing account. The facility paid interest annually in February and started paying interest quarterly in July 2020. She verified the above accounting which revealed interest for the year 2019 was not paid until 07/31/2020 and three residents currently had a negative balance in the pooled account. The facility's policy for Resident Funds, dated 11/2019, documentation included the facility shall deposit any resident's funds in excess of $50.00 in one or more interest bearing accounts which are separate from any of the facility's operating accounts, and which credit all interest when earned on the resident's account to the personal account of the resident. The facility failed to provide interest based on actual earnings on the end of quarter balances. Furthermore, the facility failed to equitably distribute interest to the residents with balances in the pooled account due to allowing residents to maintain a negative balance in the pooled account.
F 0569 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.** The facility reported a census of 64 residents and identified 36 residents with personal funds account managed by the facility. The facility further identified eight of those 36 residents whose care was funded by Medicaid. Based on interview and record review the facility failed to notify three of the eight residents, Residents (R) 73, R32, and R43, when their resident accounts reached $200.00 less than the Social Security Insurance (SSI) resource limit. If the amount in the resident's account, in addition to the value of the resident's other nonexempt resources, reached the SSI resource limit the resident may lose eligibility for Medicaid SSI. Findings included: - Review of the facility's Trust Transaction History, dated 6/1/2020 through 7/31/2020, revealed it documented the facility had 36 residents with trust accounts which included eight residents with Medicaid status. Of the eight Medicaid residents, three residents personal accounts contained balances that exceeded the $1800 balance that required notice by the facility for being within $200 of the maximum balance to qualify for Medicaid. The resident accounts and balances were as follows: 1. Resident (R)73, revealed a personal funds balance of $1928.82. 2. R 32, revealed a personal funds balance of $3046.90. 3. R 43, revealed a personal funds balance of $2256.28. On 08/03/2020 at 12:59 PM, Social Services X stated if a resident's Medicaid and trust was approaching the limit, ($1800.00) the facility should notify the resident and/or Durable Power of Attorney (DPOA) to spend down the account balance to ensure the resident received continued Medicaid coverage. On 08/03/2020 at 2:50 PM, Administrative Staff A and Social Services X verified the Medicaid funded residents as noted above with a balance that exceeded the $1800.00 and also verified that the facility had not notified these residents and/or representatives that the trust account balance was over $1800.00. The facility policy, Resident Funds, dated 11/2019, included when the amount in the residents' account reaches $200 less than the Social Security Insurance (SSI) resource limit for one person the facility will notify the resident. In addition to the value of the resident's other non-exempt resources reaches the SSI limit the facility will notify the resident. The facility failed to notify these three residents when their resident accounts reached $200.00 less than the SSI resource limit as required to ensure the residents did not lose eligibility for Medicaid SSI.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 64 residents. Based on record review and interview, the facility failed to provide confidentiality for two of the residents, Resident (R) 43 and R49. A post made on social media included the residents first names and a medical [DIAGNOSES REDACTED]. The progress note, dated 07/23/19, revealed R49 continued in isolation precautions due to a positive COVID-19 test. The COVID-19 test report dated 07/21/20 documented the test collected on 07/17/20, with a positive result on 07/21/20 for R49. The facility investigation, dated 07/27/20, revealed that on 07/22/20 at approximately 09:00 PM, Dietary staff FF posted a status on Facebook (social media website) that stated, two residents returned from hospital visits and are now positive for COVID. In the comments on the post another person asked which ones and Dietary staff FF replied to the comment and named the first names of R43 and R49. Then, Dietary staff FF commented further on the post that R49 was so weak he won't survive. Dietary staff FF's witness statement, dated 07/23/20, revealed that she did post on Facebook that the facility had COVID, and commented with the two residents first names. On 07/30/20 at 09:59 AM, Administrative staff A confirmed that she would expect all staff to follow the policy and not post resident information on social media sites. The facility policy for, Social Media Policy for Employees, undated, directed that employees may not use or disclose any client/patient identifiable information of any kind on any social media without the express written permission of the cline/patient and prior written approval from the facility. The facility failed to maintain confidentiality of R43 and R49's confidential personal information.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) The facility reported a census of 64 residents with 23 residents selected for review. Based on interview and record review the facility failed to report an allegation of abuse timely for one sampled resident, Resident (R) 36. Furthermore, the facility failed to submit completed investigations for three of the sampled residents, R36, R68, and R53 regarding allegations of abuse and neglect, to the appropriate state agency within five days of the occurrences, as required. Findings included: - Review of the facility investigation, dated 06/29/20, for an allegation of abuse, involving Resident (R)36, revealed the staff reported the allegation to the administrator on 06/15/20, and the investigation completion date was on 06/29/20 by Administrative Staff A. The investigation completion date was 14 days after the staff reported the allegation to the administrator, which was 10 working days after the allegation was made. The progress note, dated 06/15/20 at 01:22 PM, indicated the administrator spoke with R36 about a staff member being rough. The facility reported the allegation to the state agency on 06/16/20 at 03:18 PM, which was greater than 24 hours after the allegation was reported to administration. On 08/06/20 at 03:05 PM, Administrative Staff A, confirmed the investigation was reported and completed late. The facility policy Administration/Abuse, Neglect, and Exploitation, revised 11/2019, included the time period for reporting was within 24 hours, and completed reports will be submitted to the state agency within five days. The facility failed to report to the stage agency within 24 hours and failed to complete the investigation of allegation of abuse within the required timeframe of 5 days for R36. - Review of the facility investigation for an allegation of abuse by Resident (R) 68 on 05/17/2020, was submitted to the state agency on 06/17/2020, 30 days after the allegation of abuse. On 08/04/2020 at 01:30 PM, Administrative Staff A verified she was the person responsible for the completion and submission of the investigative report to the state agency. She confirmed the completed investigation of an allegation of abuse should be completed and submitted to the appropriate state agency within five days of the occurrence. Administrative Staff A agreed the submission of the investigation was not timely, as noted above. On 08/05/20 09:07 AM, Administrative Nurse D confirmed the investigative report for an allegation of abuse should be completed and submitted to the appropriate state agency by the fifth day of the event. She verified the allegation of abuse reported by R 68 was not submitted timely and was 25 days late. The facility policy for Abuse, Neglect & Exploitation, dated 11/2019, documentation included all investigations related to alleged violations involving mistreatment and/or physical abuse will be completed and submitted to the appropriate state agency within five days. The facility failed to submit a completed investigation regarding an allegation of abuse by the resident to the appropriate state agency within five days of the occurrence, as required. - The facility investigation for an allegation of neglect involving Resident (R) 53 on 05/28/2020, revealed staff submitted the facility investigation, to the state agency on 07/03/2020, 36 days after the allegation of neglect. On 08/04/2020 at 01:30 PM, Administrative Staff A verified she was the person responsible for the completion and submission of the investigative report to the state agency. She confirmed the completed investigation of an allegation of neglect should be completed and submitted to the appropriate state agency within five days of occurrence. Administrative Staff A agreed the submission of the investigation was not timely. On 08/05/2020 at 09:07 AM, Administrative Nurse D confirmed the investigative report for an allegation of neglect should be completed and submitted to the appropriate state agency by the fifth day of the event. She verified the allegation of neglect involving R53 was not submitted timely and was 36 days late. The facility policy for Abuse, Neglect, and Exploitation, dated 11/2019, documentation included all investigations related to alleged violations involving mistreatment and/or neglect will be completed and submitted to the appropriate state agency within five days. The facility failed to submit a completed investigation of neglect to the appropriate state agency within five days of the alleged neglect incident for the resident, as required. The facility
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** The facility reported a census of 64 residents, with 23 residents selected for review, including four reviewed for investigation of abuse. Based on interview and record review, the facility failed to thoroughly investigate allegations of staff to resident abuse for two of the four selected residents, Resident (R)68 and R36. Findings included: - The Medication Review Report, dated 06/03/20, for R36, included [DIAGNOSES REDACTED]., and dementia (progressive mental disorder characterized by failing memory, confusion). The admission Minimum Data Set (MDS), dated [DATE], assessed R36 with a Brief Interview of Mental Status (BIMS) score of 14, indicating she was cognitively intact. R36 could make herself understood and understand others. She had no behavior symptoms or rejection of care and required assistance with activities of daily living (ADL's). R36 was frequently incontinent of bowel and bladder. The ADL Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 06/02/20, indicated R36 required extensive assistance from one to two staff with all ADL's except eating. The Urinary Incontinence and Indwelling Catheter CAA, dated 06/02/20, included that R36 was frequently incontinent, and required extensive assistance with toileting and incontinence care. The staff were to offer toileting and incontinence care every two hours and as needed. The care plan, initiated 05/20/20, directed that staff were to offer R36 assistance with toileting and pericare every two hours while awake. The facility investigation, signed completed on 06/29/20, revealed that Administrative Staff A received a report that a staff member was too rough when caring for Resident (R)36. The investigation indicated staff completed a skin assessment at the time of allegation with no skin issues noted. The investigation lacked a witness statement from the employee that reported the allegation to the administrator as well as the roommate of R36. The two staff that did complete a witness statement, other than the staff the allegation was made against, did not work on the same shift. The investigation failed to include a plan for monitoring the on-going effectiveness of the corrective action, it provided that the facility will continue to provide training to the staff to ensure that they are competent in their duties. The skin assessment, under the assessment tab in the electronic medical record (EMR), dated 06/13/20 and 06/20/20, revealed R36 had no skin issues. The EMR lacked an assessment for skin on 06/15/20. Review of the progress notes, from 06/15/20 through 06/18/20, revealed it lacked documentation the staff was monitoring her after the allegation was made. The state intake report, dated 06/16/20, revealed that R36 did say she preferred women to take care of her. Review of the resident care plan for ADL's, revised on 06/18/20 did not include the resident's female assistance preference. The preference was not included in the facility investigation. On 08/06/20 at 03:05 PM, Administrative Staff A reported that the staff completed the skin assessment and there was no bruises or marks on the resident, and the staff forgot to document it in the medical record. Furthermore, staff should have monitored for the following days for any skin conditions following the allegation. Staff A confirmed she did not obtain a witness statement from the staff reporting the allegation, R36's roommate or staff that worked the same shift. The staff interviewed worked with the alleged perpetrator when he was hired, which was in March of 2020. Administrative Staff A reported she did talk to the night shift but did not have them complete any statements. Furthermore, she thought it was not added to the care plan about the resident's preference for female caregivers, because when interviewed R36 later, she did not remember making the accusation at all. Administrative Staff A confirmed the plan for monitoring through the QA (Quality Assurance) program did not include how the potential abuse would be monitored. The facility policy Administration/Abuse, Neglect and Exploitation, revised 11/2019, included that the facility takes all reasonable steps to investigate the incident. A summary of the investigation process and a factual and detailed description of the circumstances and events of the reported incident, and conclusions as to whether abuse, neglect, or exploitation occurred and the rationale for that conclusion. The facility failed to complete a thorough investigation of an allegation of abuse by an employee to R36. - Review of Resident (R) 68's Physician Orders, dated 06/03/2020, documentation included [DIAGNOSES REDACTED].), [MEDICAL CONDITIONS] characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and [MEDICAL CONDITION] (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The annual Minimum Data Set ((MDS) dated [DATE], documentation included the resident with the Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. She experienced depression indicators which included feeling down, depressed, or hopeless for six days of the look back period. The resident did not exhibit hallucinations or delusions or any behaviors. She required limited assistance with activities of daily living (ADLS) and required physical help by staff in part of bathing activity. The quarterly MDS, dated [DATE], revealed changes which included a BIMS score of nine, indicating moderate cognitive impairment. She did not have any depression indicators. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 10/08/2019, documentation included the resident scored an 11 on her BIMS assessment indicating cognitive impairment. Her

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) [DIAGNOSES REDACTED]. She has a history of verbally and physically aggression, frequent psychotic episodes complicated by borderline personality. The resident has a history of non-compliance with medications and treatments. She had history of thinking that the insulin the staff tried to give her was actually heroin. Her personality was described as anti-social at times. She has a history of resisting care such as toileting, personal hygiene, bathing, changing soiled clothing/underwear/briefs, etc. The care plan (CP), dated 07/20/2020, directed staff the resident with [DIAGNOSES REDACTED]. She experiences short and long term memory impairment. The resident was frequently unable to be reasoned with, she was resistant to care such as toileting, bathing, personal hygiene, changing clothes, etc. She needed a lot of encouragement to bathe at least three times a week. She required assistance of one staff with bathing. The staff were to refer the resident to psychiatric services as needed. Review of the facility investigation, dated 06/17/2020, revealed the resident alleged abuse on 05/17/2020, by a staff member. The documentation in the report included on 05/17/2020, the staff reported the allegation to the administrator that R68 reported Certified Nurse Aide (CNA) SS beat her during showers. Administrative Staff A went to the facility and interviewed the resident. The resident stated that CNA SS and she disagreed, she could not keep up with the aide's pace, and the aide would get mad. She reported CNA SS rushed her through everything which frustrated her. The facility staff called CNA SS to give her statement and who was suspended pending investigation. CNA SS denied the allegation occurred. Other residents on the hall were interviewed one of which stated that CNA SS liked to do things her way instead of the resident's way and if you do not do things her way she gets upset. Review of the facility's investigation, dated 06/17/2020, revealed on 05/17/2020, Certified Medication Aide (CMA) T reported that Licensed Nurse (LN) L told her that R68 had reported to her that CNA SS punched, pinched, and beat her when giving her a shower. CMA T reported Licensed Nurse (LN) L stated she did not believe that of CNA SS. CMA T informed LN L that it did not matter what she believed that they were mandated reporters. Then CNA T filled out the shift report and informed the Administrative Staff A of the allegation. LN L failed to report the allegation of abuse, complete a skin assessment of the resident, document anything regarding the event in the resident's medical record, or complete a witness statement. On 07/30/2020 at 08:18 AM, CMA T stated if a resident reported abuse or mistreatment, she would let the supervisor know and then document the allegation in the end of shift report, which went directly to the director of nursing and administrator. She stated the nurse should follow up on any report of abuse with an assessment and report the allegation to the administrative staff immediately. She confirmed she was told of the allegation mentioned above and she reported it on her end of shift report. CMA T stated she never witnessed someone being abusive to a resident. On 07/30/20 09:17 AM, Administrative Nurse E stated the protocol for an allegation of abuse included if anyone hears, or suspects abuse, they should report the allegation to their supervisor, director of nursing and/or administrator. The director of nursing and/or the administrator then initiate the investigation and obtain witness statements from all involved staff. The charge nurse should complete a skin assessment to determine if the resident had any injuries. Documentation of the allegation and the follow-up assessment should be included in the resident's medical record. The alleged perpetrator should be suspended immediately pending investigation. On 08/05/2020 at 09:07 AM, Administrative Staff A and Administrative Nurse D confirmed the facility failed to complete a thorough investigation to determine the root cause of the residents allegation to prevent further altercations due to LN L failure to report the allegation of abuse, failure to obtain a skin assessment or document the allegation of abuse or follow-up, as noted above. CMA T reported the allegation on an end of shift report. Administrative Staff A confirmed she came to the facility immediately and suspended CNA SS and called LN L to complete an incident report and witness statement. LN L did not come in until next scheduled day on 05/19/2020, then in the middle of the shift she walked out without completing the incident report, skin assessment, or documentation. Administrative Staff A then reported LN L to the nursing board, and educated other staff regarding abuse reporting and investigation. The facility summary report failed to include the details of LN L's failed reporting and follow-up in addressing the allegation of abuse reported to her by the resident. The facility policy for Abuse, Neglect & Exploitation, dated 11/2019, documentation included upon receiving a report of Abuse, Neglect, or Exploitation, the Administrator will cause immediate examine of the resident and ensure his or her well-being. The facility takes all reasonable le steps to investigate the incident and report the incident as required. Any situation not appropriately addressed by the facility's staff or management, should be reported to the Kansas Department of Aging and Disabilities. The facility failed to complete a thorough investigation of the resident's allegation of abuse by a staff member.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 64 residents with 23 selected for review and one of those selected for review for notice of bed hold policy and return. Based on record review and interview, the facility failed to provide a notice of bed hold policy and return for the one resident, Resident (R)56 upon transfer to the hospital on two separate occasions. Findings included: - The Discharge return anticipated minimum data set (MDS), dated [DATE], indicated Resident (R)21 discharged to an acute hospital. The Discharge return anticipated MDS, dated [DATE], indicated R21 discharged to an acute care hospital. Review of R21's medical record lacked information of a notice of bed hold policy provided to R21 for either of the hospital transfers on 06/12/20 and 06/24/20. On 08/06/20 at 10:04 AM, Licensed Nurse (LN) I, revealed when a resident transferred to the hospital the office would send a 10 day bed hold notice. On 08/06/20 at 10:13 AM, Social Services staff X confirmed that she could not find a notice of bed hold that staff provided for the resident on 06/12/20 and the staff did not send one on 06/24/20. On 08/06/20 at 10:53 AM, Administrative Nurse E revealed that social services staff was responsible for the bed holds. On 08/06/20 at 12:38 PM, Administrative staff A confirmed that she would expect all items to be completed on the Hospital Transfer Checklist when residents transfer to the hospital. The Hospital Transfer Checklist, undated, included the bed hold policy was to be signed by the resident and/or resident representative and returned to the facility. The facility policy Bed-Hold Policy, revised 11/2019, directed the resident's copy of the notice would be given at admission and sent with other papers accompanying the resident to the hospital or on therapeutic leave. The facility failed to provide a notice of bed hold policy and return for Resident (R)56 upon transfer to the hospital on two separate occasions.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 64 residents with 23 sampled for review. Based on record review and interview, the facility failed to electronically transmit Minimum Data Set (MDS) data to CMS (Centers for Medicare and Medicaid Services) within 14 days after completion for three of the 23 sampled residents, different resident MDS assessments for Resident (R)1, R3, and R56. Findings included: - The Annual Minimum Data Set (MDS), dated [DATE], for Resident (R)1, completed on 06/24/20 and staff completed the care plan decision on 06/28/20, had a status of complete rather than accepted, in the electronic medical record. Meaning the facility completed the assessment but failed to transmit the assessment to CMS. The Quarterly MDS, dated [DATE], for R3, completed on 06/24/20, had a status of complete rather than accepted in the electronic medical record. The Discharge Return Anticipated MDS, dated [DATE], for R56, had a status of complete rather than accepted in the electronic medical record. On 08/05/20 at 09:26 AM, Administrative Nurse E, revealed she completes the MDS's but does not transmit them, Administrative Nurse D was responsible for the transmission to CMS. On 08/05/20 at 10:52 AM, Administrative Nurse D revealed that after the MDS's are locked, the software system automatically creates a batch and transmits the MDS's to CMS. Furthermore, she reported she has had to contact the software company before for transmission issues and she does not have a process in place to monitor to ensure completed MDS's have been transmitted to CMS. The facility failed to ensure MDS's were transmitted to CMS within 14 days of completion for R1, R3, and R56.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 64 residents with 23 selected for review. Based on record review and interview, the facility failed to accurately assess the Minimum Data Set (MDS) for three of the 23 selected residents, Resident (R) 21 with injections, R36 with loose dentures, R39 with a pressure ulcer, and R64 with cognitive status. Findings included: -

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) Review of Resident (R) 39's signed Physician Orders, dated 06/03/2020, documented the resident admitted on [DATE] with the following diagnosis; diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), cerebellar ataxia (impaired ability to coordinate movement), and hypertension (high blood pressure). The annual Minimum Data Set (MDS), dated [DATE] revealed R39 had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS did not indicate the resident had a pressure ulcer. The Pressure Ulcer/Injury Care Area Assessment (CAA), dated 03/04/2020, identified the resident was at risk for pressure ulcers secondary to impaired mobility. Nursing staff attempted to assist the resident with repositioning and transfers. The resident would often transfer herself and refuse repositioning. Skin assessments were done routinely by a licensed nurse. Staff placed interventions into effect if the resident was noted to have skin breakdown. The quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 14, indicating intact cognition. This MDS did not indicate the resident had a pressure ulcer. Record review, revealed the following Nurses Notes, On 02/05/2020 at 12:28 PM, staff notified the nurse of an open area on the resident's bottom, which had a treatment in place, and the area worse than last week. The staff notified the unit manager and Director of Nursing. On 02/13/2020 at 10:50 AM, the area to the resident's bottom and a treatment in place, with no other redness or openings noted. On 02/27/20, the resident had an open area to the coccyx that was being treated, had discoloration, and with redness under both breasts. The note lacked measurements of these areas. On 03/05/2020, the resident's coccyx pressure open area to the bottom had a treatment in place, with no other issues. On 03/12/2020, the resident had a discoloration to the bottom with treatment in place and no other issues noted. On 03/26/2020, the resident had the open area and discoloration to the coccyx with a treatment in progress. The resident refused to wear briefs or underwear or to off load (remove weight from the area) her bottom. On 05/14/2020 at 10:59 AM, the Weekly skin assessment documented the resident had two open areas on the buttock, with a barrier cream being applied. The resident continued to refuse incontinence supplies that would help absorb the moisture. The redness remained under her left breast with continuing treatment of [REDACTED]. All other areas were clean, dry, and intact. The resident refused to use incontinent supplies. Staff applied the barrier cream as per order and her left breast was looking much better. Interview, on 07/29/2020 at 11:40 AM, with Licensed Nurse, G revealed the above MDS's to be inaccurate. The resident did have a pressure area. Interview on 07/30/2020 at 08:39 AM with Administrative Nurse D, confirmed the MDS's to be inaccurate. The Resident Assessment Instrument (RAI) was to be used for completing MDS's. The facility failed to complete an accurate MDS related to identification that the resident had pressure ulcers at the time of the assessments. - Review of Resident (R) 64's Physician Orders, dated 06/17/2020, documentation included [DIAGNOSES REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE], documentation included the resident had clear speech, makes herself-understood and understands others. Her Brief Interview for Mental Status was not assessed, as indicated by dashes throughout section C of the MDS. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 6/29/2020, documentation included the resident with [DIAGNOSES REDACTED]. She could not follow directions and was only oriented to herself. She could not hold a conversation, organize her thoughts, jumped from topic to topic, hallucinated, was delusional, experienced confusion and forgetfulness. The care plan (CP), dated 06/02/2020, directed staff that the resident exhibited decreased motivation to participate in activities of daily living (ADL's) and self- care. She experienced delusions and hallucinations, as well as increased agitation/aggressiveness. The resident had a history of [REDACTED]. On 07/27/20 at 12:07 PM, during an interview the resident stated she did not want to talk anymore and stopped talking. On 07/29/2020 at 12:00 PM, Certified Medication Aide (CMA) RR offered to get the resident up for lunch she stated no she wanted to eat in the bed. The resident confirmed she ordered and wanted the baked beans, fries, pulled pork, and lemon pie that staff served. On 07/29/2020 at 05:29 PM, Administrative Nurse E reported she coded the resident's MDS section C as not assessed (dashes) because at the time of the interview the resident would not answer the questions although she could answer. Administrative Nurse E confirmed she should have coded yes to indicate the resident should be interviewed and then dashed the remaining questions when the resident stopped participating in the interview. She reported she tried to interview the resident after she ate, but the resident gets mad sometimes after eating. Administrative Nurse E stated she should have attempted the interview at another time more acceptable to the resident. She reported she normally asked the Director of Nursing about coding questions and did not have a Resident Assessment Instrument (RAI) manual to use for guidance in coding the MDS. On 08/06/2020 at 09:49 AM, Administrative Nurse D stated the facility used the RAI manual for guidance to complete the MDS. She confirmed the resident's MDS, dated [DATE], was not coded correctly in section C. The MDS 3.0 RAI Manual, dated October 2019, page C-1, documentation instructed the interviewer that most residents can attempt the Brief Interview for Mental Status (BIMS). A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance. Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis. Structured interviews will efficiently provide insight into the resident's current condition that will enhance good care. Additionally, page C-2, directs the interviewer to code yes if the interview should be conducted because the resident at least sometimes understood. The facility failed to accurately code the MDS related to Cognition for the resident. - The quarterly Minimum Data Set (MDS), dated [DATE], assessed Resident (R)21 as receiving insulin injections for seven days during the assessment period. Review of the Medication Administration Record [REDACTED]. On 08/06/2020 at 09:49 AM, Administrative Nurse D, stated the facility used the RAI (Resident Assessment Instrument) manual for guidance to complete the MDS. On 08/06/20 at 04:12 PM, Administrative Nurse E confirmed that the resident did not receive any insulin injections for the lookback periods. The RAI manual directs to enter in item N0350A, the number of days during the seven-day look-back period (or since admission/entry or reentry if less than seven days) that insulin injections were received. The facility failed to enter the correct amount of days that insulin injections received for the seven-day lookback period for the resident's 05/27/20 MDS. - The admission Minimum Data Set (MDS), dated [DATE], assessed Resident (R)36 as not having any dental issues, which included loose dentures. The Admit/Readmit Screener, under the assessment tab in the electronic medical record (EMR), dated 05/20/20, revealed R36 had a full upper and lower denture that did not fit. On 08/04/20 at 11:38 AM, R36 revealed that she had dentures and the upper plate fit, but the lower plate was loose, even when she used denture cream. On 08/05/20 at 09:28 AM, Administrative Nurse E, confirmed that R36's admission MDS should have been coded that her dentures were loose. On 08/06/2020 at 09:49 AM, Administrative Nurse D, stated the facility used the RAI (Resident Assessment Instrument) manual for guidance to complete the MDS. The RAI manual directs to check L0200A of the MDS if the denture is chipped, cracked, uncleanable, or loose. A denture is coded as loose if the resident complains that it is loose, the denture visibly moves when the resident opens his or her mouth, or the denture moves when the resident tries to talk. The facility failed to correctly code the presence of loose dentures for R36 on the 05/27/20 MDS.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 64 residents with 23 selected for review. Based on record review and interview, the facility failed to provide a written summary of the baseline care plan for two of the selected residents, Resident (R)36 and R56. Findings included: - Resident (R)36 admitted to the facility on [DATE], per the entry Minimum Data Set (MDS), dated [DATE]. The baseline care plan, dated 05/20/20, lacked a care plan summary. The progress notes, dated 05/20/20 through 05/27/20, lacked documentation of a care plan summary provided to R36 and the resident's representative. On 08/04/20 at 03:28 PM, Licensed Nurse (LN) K revealed she did not know anything about baseline care plans. On 08/05/20 at 09:28 AM, Administrative Nurse E revealed the care plan summary was to be completed by the nurses and social services had the residents and representatives sign the base line care plan summary. On 08/05/20 at 03:28 PM, Administrative Nurse E confirmed that there was not a signed baseline care plan summary for R36. On 08/06/20 at 11:55 AM, Social Services staff X revealed that she was currently not involved with the baseline care plan process other than to remind the nursing staff to open them up in the residents' electronic medical record. On 08/06/20 at 02:35 PM, Administrative Nurse D confirmed that baseline care plans were to be done within 48 hours of admission and that the resident was to be given a summary of the care plan. The facility policy for, Baseline Care Plan, undated, directed that the completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan. The facility failed to provide a written summary of the base line care plan to R36 and the representative following admission to the facility. - Resident (R)56 admitted to the facility on [DATE] per the entry Minimum Data Set (MDS), dated [DATE]. The baseline care plan, dated 05/19/20, lacked a baseline care plan summary. The progress notes, dated 05/19/20 through 05/25/20, lacked documentation of a care plan summary provided to R56 and the resident's representative. On 08/04/20 at 03:28 PM, Licensed Nurse (LN) K revealed she did not know anything about baseline care plans. On 08/05/20 at 09:28 AM, Administrative Nurse E revealed the care plan summary was to be completed by the nurses and social services had the residents and representatives sign the base line care plan summary. On 08/06/20 at 11:55 AM, Social Services staff X revealed that she is currently not involved with the baseline care plan process other than to remind the nursing staff to open them up in the residents' electronic medical record. On 08/06/20 at 02:35 PM, Administrative Nurse D confirmed that baseline care plans were to be done within 48 hours of admission and that the resident is to be given a summary of the care plan. The facility policy Baseline Care Plan, undated, directed that the completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan. The facility failed to provide a written summary of the base line care plan to R56 and the representative following admission to the facility.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 reported a census of 64 residents with 23 residents selected for review. Based on observation, interview, and record review, the facility failed to review and revise the care plans for four of the selected residents, including three Resident (R)35, R43, and R49, for required cares for strict quarantine with positive COVID-19, and one R46 with change in frequency of hospice staff visits. Findings included: - The Medication Review Report, dated 06/30/20, for Resident (R)46, included [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS), dated [DATE], assessed R46 as having a Brief Interview of Mental Status (BIMS) score of three, indicating severe cognitive impairment. He required limited to extensive assist of staff for ADL's (activities of daily living), had a chronic disease that may result in a life expectancy of less than six months, and received hospice care. The annual MDS, dated [DATE], assessed R46 as having a BIMS score of three, indicating severe cognitive impairment. He required limited to extensive assist with ADL's, had a condition or chronic disease that may result in a life expectancy of less than six months, and received hospice care. The care plan, dated 07/07/20, revealed that hospice support was established for his neurocognitive disorder. The care plan included that the hospice nurse visited in the facility at least two times a week and as needed, the aide visited in the facility two to three times a week for personal care, and the Chaplain and social worker. The care plan lacked the frequency visits of the Chaplain and Social worker. The hospice medical record revealed the nurse visited on 04/08/20, 04/21/20, 06/11/20, 06/18/20, 06/25/20, 07/03/20, 07/15/20, and 07/30/20. On 08/03/20 at 12:33 PM, Certified Nurse Aide (CNA) QQ believed the resident received hospice services, then confirmed he was after checking with the nurse. CNA QQ was not aware of how often they visited. On 08/03/20 at 12:35 PM, Licensed Nurse (LN) K revealed that hospice does not come every week, they come approximately every other week, and if there was a change, the staff call them and they come right away. Furthermore, the nurse comes in but no aides and LN K denied seeing the chaplain come to visit the resident. On 08/05/20 at 09:24 AM, Administrative Nurse E confirmed the care plan should be updated to reflect the current status of hospice services for the resident. On 08/05/20 at 03:54 PM, Administrative Nurse D confirmed that the care plan for R46 should be updated to reflect the current visits of the hospice provider. The facility policy Care Planning, undated, directed that the plan of care will be evaluated at 90-day intervals or more frequently, based on the resident's clinical condition, car goals, and the plan for treatment, care and services and revised as needed to meet the needs of the resident's changing condition. All staff using the computerized plan of care are responsible for interdisciplinary collaboration to establish goals and appropriate interventions, as well as ongoing evaluations and revisions. The facility failed to review and revise the frequency of hospice visits on the care plan for R46. - The progress note, dated 07/19/20, for Resident (R)49, revealed testing of the resident's nares swabbed for COVID-19. The progress note, dated 07/23/19, revealed R49 continued with isolation precautions due to testing positive for COVID-19 test. The care plan, initiated on 07/20/20, lacked information regarding COVID-19 status and how to provide care for the resident in strict quarantine with COVID-19. On 08/06/20 at 02:33 PM, Administrative Nurse D revealed the care plan should have a COVID-19 problem and interventions in place. The facility policy Care Planning, undated, directed that the plan of care will be evaluated at 90-day intervals or more frequently, based on the resident's clinical condition, car goals, and the plan for treatment, care and services and revised as needed to meet the needs of the resident's changing condition. All staff using the computerized plan of care are responsible for interdisciplinary collaboration to establish goals and appropriate interventions, as well as ongoing evaluations and revisions. The facility failed to address COVID-19 on the care plan to instruct the staff on strict quarantine for R49. - Review of Review of Resident (R)35's Physician Orders, dated 06/03/2020, documentation included [DIAGNOSES REDACTED]. The annual Minimum Data Set ((MDS) dated [DATE] documented the resident with the Brief Interview for Mental Status (BIMS) score of 14, which indicated cognitively intact. He was totally dependent on staff for transfers. He required extensive assistance of staff for bed mobility, toilet use and personal hygiene. The resident had functional limitation in range of motion with the lower extremities on both sides. His [DIAGNOSES REDACTED]. He had a feeding tube and mechanically altered diet. The activities of daily living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 05/28/2020, documentation included the resident required extensive to total assistance of the staff with ADL's. The care plan (CP) in the electronic medical record (EMR), dated 06/02/2020, lacked revision of care guidance to the staff regarding strict quarantine due to the resident's positive COVID-19 test received by the facility on 07/24/2020. Review of the Blue Book communications for changes in care interventions, dated 07/24/2020 through 08/03/2020, revealed a lack of revision in care instructions to provide guidance to staff regarding strict quarantine due to his positive COVID-19 test received by the facility on 07/24/2020. Review of the resident's Miscellaneous Tab in the EMR, dated 07/24/2020, revealed the resident tested positive for COVID-19 from a nasal swab specimen collected on 07/23/2020. On 07/25/2020 at 08:20 PM, the Health Status Note in the EMR documented personal protective equipment (PPE) supplies were set up for use in care of the resident. Staff were already wearing mandated masks and gloves. On 08/03/2020 at 07:40 AM, the Health Status Note in the EMR documented the resident continued with isolation for positive COVID-19 test, lung sounds diminished but clear, no cough noted at the time of the assessment. On 07/30/2020 at 09:17 AM, Administrative Nurse E reported updates to the care plan were done by the charge nurse. Staff documented new interventions in the Blue Book to communicate new interventions or change in condition of the residents to the staff. She indicated that a positive COVID-19 test would indicate a change in condition. Administrative Nurse E reported the residents that test positive for COVID-19 were immediately placed in strict isolation/quarantine, which included isolation set up outside of their rooms that included gloves, gowns, N95 masks, shoe covers and face shields. She reported the staff received training regarding the proper use of PPE. On 08/03/2020 at 10:40 AM, Certified Nurse Aide (CNA) TT stated that the individual need and preferences of the residents were located in the care plan in the electronic medical record (EMR), and/or the Blue Book at the nurses' station to communicate changes in the resident's condition. She reported she would expect to find new interventions for a change in one of those locations. CNA TT reported that enhance precautions were in affect for the three residents that tested positive for COVID. The precautions included an isolation cart in hallway, which contained masks, gloves, booties, gowns, and goggles. She stated she did not know if the staff added the strict quarantine interventions to the resident's care plan. On 08/03/2020 at 04:10 PM, Licensed Nurse G, reported the resident's individual needs should be documented in the care plan. The nurses should update the Blue Book with any new changes in interventions and staff should check when reporting to work for changes in care. On 08/04/2020 at 09:04 AM, CNA Q reported that the individual need and preferences of the residents should be located in the care plan in the electronic medical record (EMR), and/or the Blue Book at the nurses' station to communicate changes

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) in the resident's condition. She reported she would expect to find new interventions for a change in one of those locations. On 08/04/2020 at 03:53 PM, CNA VV, reported that the individual need and preferences of the residents were located in the care plan in the electronic medical record (EMR), and/or the Blue Book at the nurses' station to communicate changes in the resident's care. He reported the care plan had not been updated to include quarantine and specific precautions for the resident since being identified as positive for COVID-19. On 08/05/2020 at 05:15 PM, Administrative Nurse D stated the care plan should be updated with changes in interventions to guide the staff in providing care to the residents. She confirmed the care plan lacked update for the resident's quarantine status. The undated facility policy Care Planning documentation included the plan of care will be evaluated based on the resident's clinical condition, care goals and the plan for treatment , care and services, and revised as needed to meet the needs of the resident's changing condition. The facility failed to review and revise the dependent resident's care plan to provide staff instructions for the resident's quarantine and specific PPE needs due to active COVID-19. - Review of Resident (R)43's Physician Orders, dated 06/03/2020, documentation included [DIAGNOSES REDACTED]. The resident had no behaviors. The resident was totally dependent on staff for transfers, locomotion and toilet use. He required extensive assistance of staff for bed mobility. The resident did not experience shortness of breath or fever. He was not quarantined or on isolation. The quarterly MDS, dated [DATE], revealed changes which included BIMS score of 12 indicating moderate cognitive impairment. The activities of daily living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 03/14/2020, documentation included the resident at risk for a decline in ADL function secondary to impaired mobility and impaired cognition. The nursing staff provided assistance with his ADL's. He preferred to stay in bed most of the time. The care plan (CP) in the electronic medical record (EMR), dated 07/20/2020, lacked revision of care guidance to the staff regarding strict quarantine due to his positive COVID-19 test received by the facility on 07/17/2020. Review of the Blue Book communications for changes in care interventions, dated 07/17/2020 through 08/03/2020, revealed a lack of revision in care to provide guidance to staff regarding strict quarantine due to his positive COVID-19 test received by the facility on 07/17/2020. Review of the resident's Miscellaneous Tab in the EMR, dated 07/21/2020, revealed the resident tested positive for COVID-19 from a nasal swab specimen collected on 07/17/2020. On 07/28/20 at 10:10 AM, Licensed Nurse (LN) I and Certified Nurse Aide (CNA) WW entered the resident's room and observed to apply personal protective equipment (PPE)which included gown, N-95 mask, goggles, gloves prior to entering the resident's room. On 08/04/2020 at 11:00 AM, the resident was no longer quarantined as a result of having two negative COVID tests. On 07/30/2020 at 09:17 AM, Administrative Nurse E reported updates to the care plan were done by the charge nurse. Staff documented new interventions in the Blue Book to communicate new interventions or change in condition of the residents. She indicated that a positive COVID-19 test would indicate a change in condition. Administrative Nurse E reported the residents that test positive for COVID-19 were immediately placed in strict isolation/quarantine, which included isolation set up outside of their rooms that included gloves, gowns, N95 masks, shoe covers and face shields. She reported the staff had received training regarding the proper use of personal protective equipment (PPE). On 08/03/2020 at 10:40 AM, Certified Nurse Aide (CNA) TT stated that the individual need and preferences of the residents were located in the care plan in the electronic medical record (EMR), and/or the Blue Book at the nurses' station to communicate changes in the resident's condition to the staff. She reported she would expect to find new interventions for a change in one of those locations. CNA TT reported that enhance precautions were in affect for the three resident that tested positive for COVID. The precautions included an isolation cart in hallway, which contained masks, gloves, booties, gowns, and goggles. She stated she did not know if the staff added the strict quarantine interventions to the resident's care plan. On 08/03/2020 at 04:10 PM, Licensed Nurse G, reported the resident's individual needs should be documented in the care plan. The nurses should update the Blue Book with any new changes in interventions and staff should check when reporting to work for changes in care. On 08/04/2020 at 09:04 AM, CNA Q reported that the individual need and preferences of the residents should be located in the care plan in the electronic medical record (EMR), and/or the Blue Book at the nurses' station to communicate changes in the resident's condition. She reported she would expect to find new interventions for a change in one of those locations. On 08/04/2020 at 03:53 PM, CNA VV, reported that the individual need and preferences of the residents were located in the care plan in the electronic medical record (EMR), and/or the Blue Book at the nurses' station to communicate changes in the resident's care. He reported the staff did not update the resident's care plan to include quarantine and specific precautions for the resident when he was identified as positive for COVID-19. On 08/05/2020 at 05:15 PM, Administrative Nurse D stated the care plan should be updated with changes in interventions to guide the staff in providing care to the residents. She confirmed the care plan lacked update for the resident's quarantine status. The undated facility policy Care Planning documentation included the plan of care will be evaluated based on the resident's clinical condition, care goals and the plan for treatment , care and services, and revised as needed to meet the needs of the resident's changing condition. The facility failed to review and revise the dependent resident's care plan to provide staff instructions for the resident's quarantine and specific PPE needed due to active COVID-19.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 64 residents with 23 selected for review, including one resident reviewed for discharge to the community. Based on record review and interview, the facility failed to complete a discharge summary or recapitulation of the resident's discharge medications for the one resident, Resident (R) 76. Finding included: - Review of the Face Sheet in the clinical record revealed Resident (R)76 admitted to the facility on [DATE] and discharged on [DATE]. Review of R76's Physician order [REDACTED].), [MEDICAL CONDITION], hypertension (elevated blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), [MEDICAL CONDITION] (rapid, irregular heartbeat), and major [MEDICAL CONDITION] (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness). Review of the Admission, Minimum Data Set ((MDS) dated [DATE], indicated the resident had a Brief Interview of Mental Status (BIMS) score of 15, indicating cognitively intact, that an active discharge plan was in place, and he did not need referral to the community. Review of the discharge return not anticipated MDS, dated [DATE], revealed it indicated R76 had a BIMS score of 15, indicating cognitively intact, that he needed limited assistance for toilet use, transfers, dressing, personal hygiene, and assistance with bathing. R76 was always continent of bowel and bladder. Review of the physician progress notes [REDACTED]. The infection completely resolved and his breathing was back to normal. Review of the nurses' notes, dated 05/22/2020 at 10:21 AM, included orders to discharge the resident to assisted living. Review of the clinical record revealed it lacked a discharge summary that included a recapitulation of R76's stay, a final summary of his status at the time of discharge, reconciliation of all discharge medications, and a post-discharge plan of care. Interview, on 08/04/2020 at 11:03 AM, with Licensed Nurse (LN) G, revealed discharge summaries were completed after a discharge. Interview, on 08/04/2020 at 02:43 PM, with Administrative Nurse D, revealed the nurses start the discharge summary, then it was forwarded to other departments. The unit managers track the discharge summary. The facility policy, Resident Discharge, revised 11/2019, indicated if a resident is discharged to another facility, transfer, and referral forms are made out by the nurse and sent with resident. The original goes with the resident and the copy stays with the medical record .A Nursing Discharge Summary will be collected in full and placed in the medical record. The includes recapitulation of stay and reconciliation of medications. The facility failed to complete a Discharge Summary for R76 upon discharge from the facility on 05/22/2019, to inform the resident and assisted living facility, a final summary of her status, reconciliation of her medications upon discharge, and a post-discharge plan of care.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 64 residents, with 23 selected for review and included two residents reviewed for activities of daily living. Based on observation, record review, and interview, the facility failed to provide the necessary services to maintain personal hygiene for one of the two selected residents, Resident (R) 52 related to grooming of chin hairs. Findings included: - The Physicians Order Sheet, dated 06/03/2020 for Resident (R) 52 included [DIAGNOSES

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) REDACTED].), dementia (progressive mental disorder characterized by failing memory, confusion), paranoid personality disorder (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Admission Minimum Data Set, (MDS), dated [DATE], assessed R52 with a Brief Interview of Mental Status (BIMS) score of six, indicating severely impaired cognition. She required supervision for bathing. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 12/13/2019, revealed R52 required cueing/supervision with ADL's. Nursing staff were to continue providing the resident with assistance with ADL's as needed. The quarterly MDS, dated [DATE], revealed the resident had a BIMS score of four, indicating severely impaired cognition. She required supervision with personal hygiene and bathing. The care plan, dated 07/20/2020, included that R52 preferred to take showers three days a week and she required supervision with ADL's, dressing, and personal hygiene. Observation, on 07/27/2020 at 03:35 PM, revealed R52 with facial hair long enough that it curled on her chin. Interview, on 07/27/2020 at 03:35 PM, with R52 revealed she would like to have her chin hairs trimmed and she was unaware the staff could do that here. Observation, on 07/28/2020 at 09:30 AM, revealed R52 with the facial hair remaining on her chin. Observation, on 07/29/2020 at 02:00 PM, revealed R52 continued to have the facial chair on her chin. Interview, on 07/29/2020 at 12:04 PM, with Certified Nurse Aide (CNA) P revealed, staff should trim chin hairs on women, if they would allow it. Interview, on 07/29/2020 at 05:06 PM, Licensed Nurse (LN) H revealed the CNA's were expected to shave women with chin hairs. Interview, on 07/30/2020 at 08:39 AM, with Administrative Nurse D revealed CNA's should shave women with each bath or as needed. The facility policy for Quality of Care, undated, revealed that any resident who is unable to perform activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .Residents are dressed and groomed in a manner that preserves personal dignity. The facility failed to provide necessary services for removal of the resident's facial hair to maintain good personal hygiene.
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 reported a census of 64 residents, with 23 selected for review including three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to implement new and appropriate interventions following falls to prevent further falls for one of the three residents, Resident (R)21. Findings included: - Resident (R) 21's Medication Review Report, dated 06/03/20, included [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS), dated [DATE], assessed Resident (R)21 as having a Brief Interview of Mental Status (BIMS) score of 09, indicating moderate cognitive impairment. The Annual MDS, dated [DATE], assessed (R)21 as having a BIMS score of 11, indicating moderate cognitive impairment. R21 required limited assist of one for bed mobility, transfer, locomotion on/off unit, dressing, toileting, and hygiene. She was supervised with walking in/out of her room. She had one non-injury fall since admission or the prior assessment, and two or more falls with injury except major injury since admission or the prior assessment. The quarterly MDS, dated [DATE], assessed R21 as having a BIMS of 12, indicating moderate cognitive impairment. She required limited assist of one for all activities of daily living (ADL's) except eating. She had two or more non injury falls since the prior assessment. The Falls Care Area Assessment (CAA), dated 02/07/20, indicated that R21 had several falls, she attempted to grab things from the floor, and was in denial about her abilities so she did not call for help. She had difficulty with transfers and toileting at night, she was fatigued by that time, but she still attempted to do things on her own. The staff were to check on her every two hours and offer ADL assistance including toileting. The Cognitive Loss/Dementia CAA, dated 02/07/20, indicated that R21 had dementia. She was alert and oriented to person, place, and time, however other times she had confusion and did not where she was at. Depending on the day, R21's BIMS could be a 15 (indicating cognition intact) or a four (indicating severe cognitive impairment). The ADL CAA, dated 02/07/20, indicated that R21 needed assistance of one person with bed mobility, transfers, and often did not call for help. She was in denial about her abilities. The staff were to offer the resident assistance with ADL's every two hours. The Urinary Incontinence and Indwelling Catheter CAA, dated 02/07/20, indicated that R21 was mostly continent, but had accidents at night. She had more incontinence depending on her mood and how she feels. She had functional incontinence, and staff were to offer the resident assistance with toileting and peri care. The Care Plan, in place as of 01/19/20, included R21 was at risk for falls related to impaired safety awareness, history of multiple falls, and use of antidepressants (class of medications used to treat mood disorders and relieve symptoms of depression) and antipsychotics (class of medications used to treat [MEDICAL CONDITION] and other mental emotional conditions). Interventions in place included to ensure R21 was wearing non-skid socks when in bed, and non-skid socks or shoes when up in the wheelchair. She had been educated to have staff turn off her TV if her remote was not working, and importance of locking the wheels on her four wheeled walker anytime she was getting on/off her walker. However, education is an inappropriate intervention when the resident has confusion, as she would not remember the education provided. The Post Incident/Accident Investigation, dated 01/19/20, revealed at 05:30 PM, R21 fell in her room reaching forward to pick up something from the floor and slid out of bed. She hit her head on the closet door and received a laceration (wound to the skin) above her left eye. The progress note, dated 01/19/20 at 05:30 PM, indicated that the staff educated R21 to call for help when needing assistance and staff would request a reacher stick (extension grabber) from the therapy department. The intervention to educate her to call for help when needing assistance was inappropriate related to her BIMS score of nine. The care plan interventions, revised on 01/20/20, included that the staff were reminded to park her front wheeled walker at the bedside for easy access when getting up to ambulate, remind to use call light when needing assistance off of the toilet, and not to leave her alone in the bathroom. The intervention regarding locking the wheels of her walker was resolved on 01/20/20. The care plan failed to include providing her the previously planned reacher stick. The Post Incident/Accident Investigation, dated 01/21/20, revealed at 06:30 PM, R21 was in bed with a bruise and a little blood on the left side of her eye. She was trying to move the bedside table from her bed when the left side of her face hit the foot of the bedside table. The care plan intervention, dated 01/21/20 and revised 04/09/20, included to keep needed items close to her when she was in bed. The Post Incident/Accident Investigation, dated 02/08/20, revealed at 01:15 PM, R21 was found on the floor in front of her bed on her left side with her head resting on a wheel of the wheelchair. She stated she was trying to get back out of bed to use the restroom. She received a skin tear to her right arm. The care plan intervention, dated 02/08/20, revealed staff removed R21's personal bed from her room and replaced it with a facility high/low bed. This intervention was resolved on 07/29/20. The Post Incident/Accident Investigation, dated 02/14/20, revealed at 02:30 AM, R21 was on her knees with both hands in her wheelchair facing the foot of her bed, and her legs were towards her nightstand. The resident reported that she had went to the bathroom by herself without her wheelchair and when she was coming back, she tripped and fell on her stomach. The progress note, dated 02/14/20 at 02:30 AM, indicated the resident fell with regular socks on her feet, her house shoes and the bed's remote was on the floor towards her right side. Per the aide, her room light was not on, her call light was not on, and the floor was dry. The immediate intervention was the staff educated to take her to the bathroom every two hours. Furthermore, in the note, it indicated the intervention was for non-skid socks while in bed and a night light in her room. Review of the care plan, dated 06/02/20, lacked an intervention for a night light in the room. There was an intervention dated on 11/19/19 and revised on 02/14/20, to check frequently that R21 had her non-skid socks on, and family would be asked if the box spring could be taken off of the bed so that her bed could be a little lower to the floor. The intervention for non-skid socks was already in place on the care plan prior to the fall. A care plan intervention dated 07/31/19, revised on 02/18/20, revealed that staff educated R21 to ask for assistance when wanting/needing to get into her closet for any reason. This intervention was inappropriate as she had moderate cognitive impairment. A new intervention, dated 02/14/20 and revised on 07/08/20, revealed staff placed R21 on visual checks every two hours and toileting would be offered at this time. Also, staff placed a pink leaf on her door, with the door to remain open. The Post Incident/Accident Investigation, dated 02/17/20, revealed at 09:40 PM, R21 was in her room on the floor on her bottom with legs forward facing the bathroom door and under the wheelchair. The resident was unable to say what had happened but that she was going to use the bathroom, and that non-skid socks were on her. The investigation failed to address when the last time staff assisted R21 to toilet. The progress note, dated 02/17/20 at 09:40 PM, revealed at the time of the fall the call light was not on and R21 had regular socks on. The immediate intervention was that staff would place nonskid socks on her. Furthermore, it indicated the resident was not wearing proper footwear and the intervention was for the call light to be in reach and to wear non-skid socks while in bed.

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	175520	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VICTORIA FALLS	224 E CENTRAL ANDOVER, KS 67002

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** - Few	(continued... from page 7) The intervention of nonskid socks while in bed was a duplicate intervention, previously implemented on 02/14/20. The care plan, dated 06/02/20 and revised 07/29/20, included an intervention for fall dated 02/17/20, that signs placed in R21's room to remind her to please use call light to request assistance to the toilet. The Post Incident/Accident Investigation, dated 03/16/20, revealed at 07:25 PM, R21 was on the floor in the bathroom between the bathroom door and the sink. The resident reported after using the bathroom she got up to go to the wheelchair and fell on the floor. The progress note, dated 03/16/20, indicated that staff instructed the resident to lock her wheelchair before getting up. The immediate intervention was that staff told R21 to lock her wheelchair before getting up. Furthermore, the intervention was for staff education, resident/family education, and non-skid socks while in bed. This intervention was not added to the comprehensive care plan dated 06/02/20. Education was not appropriate due to her having moderate cognitive impairment. The progress note failed to address how long it had been since the staff assisted the resident to toilet. The Post Incident/Accident Investigation, dated 03/21/20, revealed on 06:25 AM, the resident slipped in her bathroom and hit her head on the sink. She reported she had to go to the bathroom badly, so she went by herself and slipped and hit her head on the sink. The progress note, dated 03/21/20 at 06:25 AM, revealed R21 was advised to wear non-slip socks or shoes when going to the restroom. The immediate intervention was that staff gave R21 non-slip socks. The note failed to address the last time the staff assisted the resident with toileting. Furthermore, the note included an intervention of resident/family education and nonskid socks while in bed. The care plan, dated 06/02/20, included an intervention for the 03/21/20 fall. Staff reminded R21 to wear non-skid socks and gave her more to keep in her drawer. The night shift staff were to ensure that non-skid socks were on when staff assisted her to bed. The intervention to remind R21 to wear non-skid socks was a duplicate intervention and not appropriate due to her cognition level. The Post Incident/Accident Investigation, dated 03/25/20, revealed at 08:05 AM, R21 fell in her room. She reported that she tripped and fell on her face. R21 received a one centimeter (cm) laceration to her right eyebrow. The progress note, dated 03/25/20 at 08:05 AM, revealed a staff heard a loud noise in R21's room and found her laying on her right side with her face on the floor. She was more confused than normal and complained of urinary urgency. Staff received new orders from the physician to obtain lab on the next lab day. The immediate intervention was to remind R21 to call for help and the other intervention was to rule out/treat infection. The progress note failed to address if nonskid socks were in place or when the last time staff assisted R21 with toileting. The care plan, dated 06/02/20, revealed the intervention for the fall on 03/25/20 was for R21 to have a therapy evaluation, to obtain a urinalysis, and she would continue to wear nonskid socks. The intervention was not an immediate intervention to prevent further falls. The intervention was resolved on the care plan on 07/29/20. The progress note, dated 03/31/20 at 03:03 AM, revealed the nurse was alerted by R21's roommate at 02:35 AM, that she was on the floor. R21 was laying on the floor between the bathroom and bed. R21 had said she was on her way to the bathroom and fell , she forgot to use the call light. The Post Incident/Accident Investigation, dated 01/21/20 rather than 03/31/20, included the immediate intervention to prevent reoccurrence was for staff to place non slip socks on the resident. The intervention was a duplicate intervention. The care plan, dated 06/02/20, revealed the intervention for the fall that occurred on 03/31/20, was that staff referred R21 to and picked up by therapy for services to work on balance, transfers, and strengthening. On 07/29/20 at 08:57 AM, R21 was in her room resting in bed with eyes closed. The wheelchair was near the foot of the bed with antiroll bars in place. The room lacked signage to remind her to use the call light and the door was shut to her room. Review of the care plan, dated 06/02/20, revealed it lacked an intervention of the use of the antiroll bars to the wheelchair. On 07/29/20 at 10:27 AM, the door to R21's room was shut. The wheelchair was away from the bed out of reach and the walker was in the corner of the room out of reach. R21 had socks in place but they lacked a nonskid surface with R21 in bed. The facility failed to follow the care plan and have nonskid socks on R21 and failed to have the walker within reach next to the resident in bed. On 07/29/20 at 12:46 PM, Certified Nurse Aide (CNA) MM revealed R21 at risk for falls. Her interventions included a floor mat, call light, verbal reminders to ask for help, and visual checks done when going by her room. Furthermore, she reported R21 tried to get up on her own without using the call light. The door to the room was kept closed due to COVID procedure, otherwise it was open. The wheelchair or the walker was to be beside her when she was in bed, but it was better if it was not. If it was not, then R21 did not try to get up and if they were there she would try to get up on her own. On 07/30/20 at 08:42 AM, R21 was in bed with her eyes closed, her walker was out of reach by the dresser and her wheelchair was out of reach next to the wall past the foot of the bed. The overbed table was also out of her reach. The facility failed to ensure the walker and the overbed table were in her reach that had personal items on it. The care plan, dated 06/02/20, included and intervention on 04/09/20 to keep needed items close to R21 when she was in bed. On 08/04/20 at 12:47 PM, CNA LL assisted R21 to lay down then exited the room. The resident's nonskid socks were not in place. On 08/04/20 at 12:49 PM, CNA LL confirmed that R21 should have nonskid socks in place. On 08/05/20 at 09:41 AM, Administrative Nurse E explained that when a fall occurred the staff should figure out if fall interventions were in place at the time of the fall and an immediate intervention should be put in place. The nurse should monitor after the fall to ensure the intervention was appropriate. Furthermore, she explained that education was not appropriate for residents with a BIMS score of 9 (Confusion). Administrative Nurse E confirmed that the care plan lacked an intervention for the fall on 01/19/20, the reacher stick was not added. The intervention for the high/low bed should be on the care plan and it was not. She also confirmed that the intervention for the fall on 02/14/20 was a duplicate intervention and the night light was not on the care plan. Administrative Nurse E also confirmed there was not any signs in the room to remind R21 to ask for help. Her fall on 03/16/20 had a duplicate intervention of nonskid socks and that the nurse should be documenting the last time she was toileted. She also confirmed that education was not appropriate due to her cognition, including the intervention to lock the wheelchair. The anti-roll bars to the wheelchair should be on the care plan and were not. Administrative nurse E also confirmed the 03/21/20 intervention for the fall was a duplicate intervention and education was not an appropriate intervention. Furthermore, the intervention for the fall on 03/25/20, to remind to R21 to use the call light was not appropriate, duplicate interventions in place, and no immediate intervention was put in place. On 03/31/20 the intervention for nonskid socks was not appropriate as well. Administrative Nurse E confirmed R21's walker should be within reach when she was in bed and nonskid socks should also be in place. On 08/06/21 at 03:24 PM, Administrative staff A revealed she expects the Director of Nursing to review the falls after occurrences to include review of the interventions to make sure everything was in place. She would also expect new interventions to be added to the care plan for each fall. The facility policy Accident/Incident Report Investigation and Prevention, revised 11/2019, identified that all accidents and incidents are recorded, investigated and corrective measures initiated. It is the responsibility of the licensed nursing professional to implement care plan changes to prevent repeat incidents. Follow-up of resident status should be in nurses notes every shift for a period of 72 hours. Investigation needs to occur immediately, and appropriate and non-repetitive care plan intervention needs to be initiated immediately to prevent recurrence. The facility failed to implement new interventions and appropriate interventions following repeated falls to prevent further falls for Resident (R)21.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 64 residents with 23 residents sampled which included two residents reviewed for catheters. Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services regarding catheter care for Resident (R) 43, to prevent urinary tract infection. Findings included: - Review of Resident (R) 43's Physician Orders, dated 06/03/2020, documentation included [DIAGNOSES REDACTED]. The annual Minimum Data Set (MDS), dated [DATE], included Brief Interview for Mental Status (BIMS) score of 13, which indicated cognitively Intact. The resident was totally dependent on staff for transfers, locomotion, and toilet use. He had an indwelling urinary catheter. The quarterly MDS, dated [DATE], revealed changes which included a BIMS score of 12 indicating moderate cognitive impairment. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 03/14/2020, included the CAA triggered secondary to dependence with toileting and because of a suprapubic catheter. The care plan (CP), dated 07/20/2020, directed staff To ensure his catheter bag and tubing were below the level of his bladder. On 08/04/2020 at 02:26 PM, Certified Nursing Assistant (CNA) N and Q dressed the resident. CNA Q raised the catheter bag above the bladder to position it through his pant leg. Both CNAs confirmed the catheter tubing was raised above the resident's bladder. CNA N and Q proceeded to transfer the resident to his wheelchair. CNA N placed the catheter bag directly on the floor while replacing the dignity bag. She confirmed she placed the catheter bag and tubing directly on the floor. She stated the

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	175520	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VICTORIA FALLS	**224 E CENTRAL ANDOVER, KS 67002**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) catheter bag and tubing should be kept off the floor to prevent infections to the resident. On 08/04/2020 at 3:59 PM, Licensed Nurse (LN) J stated she expected the staff to keep the residents' urinary catheters below the bladder level at all times and staff should never lay a catheter bag and/or tubing directly on the floor. On 08/05/2020 at 05:07 PM, Administrative Nurse D stated staff should maintain a catheter and the tubing below the bladder and off the floor to prevent infections. The undated facility policy for Emptying a Urinary Drainage Bag, documentation included prevent the drainage bag from becoming full and allowing urine to flow back into the bladder. The policy did not address maintaining the catheter below the bladder and keeping the bag and tubing directly off the floor. The facility failed to provide the necessary treatment and services regarding catheter care during cares for the resident to prevent urinary tract infections.
F 0692 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 64 residents with 23 selected for review and four reviewed for nutrition. Based on observation, interview, and record review, the facility failed to provide and monitor interventions to prevent significant weight loss for Resident (R)21, who experienced a significant weight loss of 5.17 percent in one month and 16.3 percent in six months. Findings included: - The Medication Review Report, dated 06/03/20, for Resident (R)21, included [DIAGNOSES REDACTED]. The report also included an order for [REDACTED]. The Annual Minimum Data Set (MDS), dated [DATE], indicated R21 had a Brief Interview of Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. She did not reject care, was independent with eating, did not require setup help, and had no swallowing disorders or weight loss. She was on a therapeutic diet and had no dental issues. The Nutritional Status Care Area Assessment (CAA), dated 02/07/20, revealed that R21's current weight of 114 pounds was a 5.3-pound weight loss in the past year. She received a regular diet with ground meat per her request, and her average meal intake was 50-75 percent. The facility offered her super shakes (a high calorie supplement) three times a day with meals, a Magic Cup (a high calorie and protein supplement) twice a day, and staff added one tablespoon of protein powder to her food at each meal. Furthermore, it indicated the dietary profile was complete, the care plan reviewed, with no changes to the dietary interventions at that time. R21 was known to skip meals and leave food on her plate and staff offered snacks to her frequently. Additionally, she had an abscess (cavity containing pus and surrounded by inflamed tissue) recently treated that slowed her eating due to pain. She was often confused, could make her needs known, and staff would continue to offer the resident health shake and snacks. The Quarterly MDS, dated [DATE], indicated R21 had a BIMS score of 12, indicating moderate cognitive impairment. She did not reject care, was independent with eating, did not require setup help, and had no swallowing disorders. She had weight loss of five percent or more in the last month or a 10 percent loss in the last six months. R21 received a therapeutic diet and had no dental issues. The Care Plan, dated 06/02/20, included a problem for nutrition, she received a regular diet with ground meat per her request, and she frequently skipped breakfast. When she ate, she liked items such as eggs, toast, bacon, sausage, and cereal. She usually chose foods off the menu for lunch and supper, and she liked creamed corn. Staff should offer the resident super shakes three times a day with meals, Magic cups twice a day, and staff added one tablespoon of protein powder to her food at meals. Interventions for her Nutrition problem included: On 01/19/18, revised on 02/22/18 - Add one tablespoon of protein powder to her food at each meal. On 12/10/18 - Regular diet with ground meat per her request. On 04/02/19 - offer R21 a super shake with meals and as a snack throughout the day if she was hungry. On 05/30/19 - Offer a Magic Cup to R21 at lunch and supper. On 10/16/19 - R21 frequently skipped breakfast, but staff should offer her something to eat. On 01/20/20 - R21 frequently skipped breakfast, but when she ate, she liked a variety of items such as eggs, toast, bacon, sausage, and cereal. For lunch and supper, she usually chooses the meal from the menu. On 06/19/20 - Staff were to get R21 up for meals. Due to her dementia process she may not realize that she was hungry or that it was mealtime. Instead of asking if she was ready to eat, use statements like it was time for lunch or let's go to the dining room for supper. Review of R21's weights, under the Weights/Vital Sign tab in the electronic medical record (EMR) revealed the following weights: On 01/08/20--114.0 pounds. On 02/06/20--115.1 pounds. On 03/10/20--119.0 pounds. On 04/17/20--102.5 pounds-which is a 13.9 percent significant weight loss in the past month. On 05/08/20--102.6 pounds. On 05/20/20--103.9 pounds. On 05/29/20--103.7 pounds. On 06/08/20--100.6 pounds. On 06/18/20--93.8 pounds - which is a 9.72 percent significant weight loss in the past month. On 06/24/20--96.4 pounds. On 07/03/20--95.4 pounds - which is a 5.17 percent significant weight loss in the past month, and a 16.3 percent significant weight loss in the past 6 months. The Nutritional Assessment, dated 02/05/20, indicated R21's current supplements were shakes three times a day and one tablespoon of protein powder three times a day. The facility's Weight Loss/Gain Communication Form, dated 04/23/20, revealed a current diet order of regular ground meat per her request, current interventions of super shakes with meals, magic cups twice a day, and one tablespoon of protein powder three times a day with meals. Her food intake ranged from 0-100 percent in the morning, 75 percent at noon, and 75 percent in the evening. F21 was not on hospice, it was not an unavoidable weight loss, and not a planned weight loss. Her recent weights: 01/08/20 of 114 pounds, 02/06/20 of 115.1 pounds, 03/10/20 of 119 pounds, and 04/17/20 of 102.5 pounds. A handwritten note, next to 04/17/20 weight was, Is weight accurate? The summary revealed staff believed it to be an inaccurate weight documented. Dietary staff EE signed the form on 04/23/20, Administrative Nurse D signed it on 04/30/20, and the physician signed it on 05/01/20. The communication form lacked any new orders or instructions. The Dietary Note, dated 04/29/220 at 09:57 AM, revealed R21's current weight of 102.5 pounds was a 11.5-pound loss in the past 90 days. The note recommended no changes to the resident's dietary interventions at this time. The Nutritional Care Form, dated 06/10/20, by Dietary Staff FF, indicated she followed R21 related to the significant weight loss over 90 days and at 180 days marks. Furthermore, it indicated weight loss over the last month was slowing and the cause of the weight loss at this time was unclear. The recommendation was to monitor intakes closely and check weekly weight. The Dietary Note, under the Progress Note tab, dated 06/19/20, revealed the weekly weight committee noted R21 weighed 93.8 pounds and had a weight loss of 6.8 pounds in the past seven days. The interdisciplinary team believed some of the decreased intakes were due to her dementia. The staff updated the resident's care plan for staff to make certain she was getting up for meals and to tell her it was time for a meal (not to just ask if she was ready to eat). Restorative dining was a consideration but was not in place at the time. The physician's Progress Note, dated 07/10/20, indicated R21 had abnormal weight loss, five to-10 pounds in less than a month and her appetite decreased. A Telephone Order, dated 07/10/20, revealed [MEDICATION NAME] (class of medications used to treat mood disorders, relieve symptoms of depression, and as an appetite stimulant) 7.5 milligrams (mg) for weight loss and protein shakes three times a day for weight loss. (The resident already had a shake planned in place for three times a day. The shake order was not on the medication administration record.) On 07/29/20 at 10:29 AM, R21 reported she was not eating breakfast today and that she usually did not, and she usually ate lunch at 11:30 AM. On 07/29/20 at 11:38 AM, R21's meal was brought to her room, she was sitting on the side of the bed. Staff served her beef and broccoli with rice, snap peas, bread and butter. The resident's hall tray lacked the posted dessert of Apple Brown(NAME) and staff failed to offer the resident her supplements of a super shake and Magic Cup. At 11:54 AM, staff returned to the resident's room, and the resident spilled her beef and broccoli on her gown. The resident reported she had difficulty chewing the beef and broccoli, and staff replaced the spilled food with ground beef over rice, however, failed to offer the resident dessert, a health shake, or a Magic Cup. On 07/29/20 at 12:40 PM, Certified Nurse Aide (CNA)MM responded to R21's call light, she wanted to go to bed, she reported she was super tired, just could not eat, and denied having any stomach pain. Observation revealed the resident consumed approximately 20 percent of her meal. However, the clinical record revealed the resident consumed 76-100% of lunch. The facility failed to document the correct amount of meal consumed, as evidenced by the observation. On 07/29/20 at 12:46 PM, CNA MM confirmed that R21 ate approximately 20% of her lunch and that she was usually a pretty good eater. She did not usually eat breakfast unless an occasional piece of French toast. She had a milkshake this morning, a strawberry protein shake from the kitchen, and she usually has one every morning. CNA MM reported she tried to give her one every meal and that staff asked R21 about any dessert when the staff served the resident the meal because there were several options to choose from. On 07/29/20 at 05:10 PM, Dietary Staff BB, reported they have a clipboard with a list of all the residents that had the type of diet they were on, adaptive devices, supplements, etc. He confirmed that R21 was on a regular diet with ground meat if she requests, super shake with meals, Magic Cup with lunch and supper, and one tablespoon of protein powder in food at meals. The nursing staff takes care of the protein powder. The magic cup sometimes was given with the meal or 5-10 minutes later, after they were eating, or whenever they want it really. Furthermore, he reported that nursing takes care of giving out the shakes, but the kitchen made them. On 07/29/20 at 05:16 PM, CNA MM revealed that the nursing staff administered the resident's protein powder in her shakes. She verified staff failed to provide the resident protein powder and shakes at each meal. On 07/30/20 at 11:55 AM, staff served R21 her lunch meal of lemon pie, pink lemonade, baked beans, lattice fries, barbeque brisket sandwich (was in small pieces and covered with

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	175520	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VICTORIA FALLS	224 E CENTRAL ANDOVER, KS 67002

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 9) sauce), and 2 cookies. However, the staff failed to serve the resident the planned super shake and the Magic Cup. On 07/30/20 at 12:12 PM, R21 removed the top bun off of the sandwich. R21 reported the meat was a little spicy, but better than yesterdays. She ate some beans, then picked up a fry and took a small bite. On 07/30/20 at 12:37 PM, R21 continued eating her lunch meal, with half of her beans gone, the fries were moved off of her plate and on the overbed table, it appeared some of the meat was gone off of her sandwich, and she had not eaten any of her pie yet. On 07/30/20 at 12:46 PM, Dietary staff CC confirmed nursing was responsible for adding the protein powder to R21's food and staff added it before they took it to the resident's room after the cook prepared the plate. The Magic Cups were sent out when staff returned to grab it after the resident eats, so it would not melt. It was like ice cream. Furthermore, she reported that health shakes were sent out with a meal and R21 was to get a super shake with her meals. A super shake looks like a vanilla shake with lots of nutrients to help them gain weight. It is premade in the kitchen. On 07/30/20 at 12:52 PM, Certified Medication Aide (CMA) RR reported the kitchen adds the protein powder to R21's food, and that staff did not serve R21 a super shake for lunch today, but it was usually served with the meal. Furthermore, CMA RR was not sure if she received the Magic Cups, but the resident did like ice cream. CMA RR reported that health shakes are documented on the Medication Administration Record (MAR), however, CMA RR verified R21's supplement was not on the MAR. On 07/30/20 at 12:57 PM, R21 was in her wheelchair exiting the bathroom and CMA RR entered her room, and R21 told him she wanted to take a break and lay down, but not to take her food as she was not done drinking. CMA RR confirmed the liquids on her table were water and pink lemonade. The facility failed to provide R21 with a shake and a Magic Cup as planned. On 07/30/20 at 01:01 PM, dietary staff DD explained that R21 did not receive Magic Cups, then looked at the clipboard and reported that R21 was supposed to get one. Dietary staff DD confirmed that R21 did not get a Magic Cup for lunch and they usually go out with the meal, and that she usually writes those on the resident's meal ticket. The Task tab, for amount eaten of Magic Cup for lunch on 07/30/20, in the EMR, documented the resident refused the magic cup. On 07/30/20 at 01:15 PM, CNA MM reported R21 ate half of a shake this morning between six and seven AM and refused a shake at lunch. The staff offered the shake to her again at approximately 10:45 AM and she refused. She did not get a Magic Cup with lunch, but the staff would offer it to her around 2:00 PM. The amount eaten Task, for the shake, for 07/30/20, revealed no documentation for the intake of the morning or afternoon shake. On 07/30/20 at 01:19 PM, Licensed Nurse (LN) I, reported R21's weight loss interventions included a house shake three times a day-a high calorie protein shake, and [MEDICATION NAME] 7.5 milligrams (mg) at bedtime. The CNAs should receive the shakes from the dietary department. The CNAs were responsible for documenting the supplemental shakes. LN I reported the staff had not informed her of any refusals from R21 today. LN I further explained the staff were not weighing anyone at this time due to positive COVID-19 cases in the building. On 07/30/20 at 01:31 PM, Dietary staff EE, confirmed R21's diet was regular with ground meat upon her request, super shakes three times a day, Magic Cup twice a day, and protein powder one tablespoon added to her food at each meal. Super shakes were kept in the refrigerator in the dining room where staff could get to them and the staff also had them listed on the sheet so they could send them out. It alerted staff on the Kiosk (a small, stand-alone device providing information for staff on a computer screen and was often used for entering services provided) for CNAs to document as well as documentation on a clipboard, so nursing staff could look at too. The staff could write the supplements on the tickets, but it was not done in advance, so staff were to look at the clipboard in case there had been any changes. The nurse aide should be checking to make sure everything was there when the dietary staff prepared the resident's meal. The Magic Cups should be sent out with lunch and supper by the dietary staff on the tray. The protein powder should be put on the food by the dietary staff, if it was difficult to add to the food, depending on what the resident ordered, then it could be added to a shake. Furthermore, Dietary staff EE explained that interventions put in place for R21 since the weight loss in April was nothing new, as she was already on shakes, Magic Cup, and protein powder, and staff notified the physician with no new recommendations. On 06/19/20 the weight committee met and believed the loss was related to the resident's dementia and added that to the care plan to make sure staff were getting her up for meals and not asking if she was ready because she would always say no. Dietary staff EE reported I look at the weights once they are put in for the month reweights determined by a significant weight loss or gain, and if the weights were out of range. Staff documented the reweights in the chart notes. She was reweighed in April and June and determined to be accurate weights. On 04/30/20, staff were to reweigh and confirmed the weight was accurate. Staff should weigh the resident monthly, now weighed weekly for about a month and a half because the dietician wanted to keep an eye on her. We were not weighing any residents currently due to room isolation that started the first part of last week. R21's last weight was on 07/03/20 and ended the weights on 06/24/20 because she had actually gained weight at that time. Dietary staff EE confirmed R21 should have been changed back to a weekly weight after the lower July weight. She also confirmed she did not know why they ordered the shakes in July when the physician ordered the [MEDICATION NAME], as it was the same thing she was already getting. On 07/30/20 at 02:10 PM, Administrative Nurse D revealed that R21 was losing weight, but was unsure if it was a significant loss or not. No new interventions were added when her weight dropped in April, as she already had interventions in place, and the staff may have just continued to monitor the resident. R21 should receive house shakes, protein powder, Magic Cup, and an appetite stimulant. She skipped breakfast, but staff should still offer her something to eat. In June, the care plan intervention revised to let the resident know it was time to eat and staff should not ask if she was ready to eat. Administrative Nurse D reported she was not aware if the interventions were effective or not, as the unit managers looked at that and she was unsure where the percentages of supplements documented, but thought they were to be documented somewhere. On 08/04/20 at 12:04 PM, CNA LL served R21 her lunch. A Magic Cup was not served but was listed on the meal ticket. On 08/04/20 at 12:23 PM, CNA LL reported that R21 does not like Magic Cups. The 08/04/20 Magic Cup intake was charted in the EMR as 0-25% consumed for the lunch serving, when it wasn't offered per observation and interview. The dietary note, under the progress note tab, dated 08/05/20 at 11:30 AM, by Consultant FF, revealed an unclear cause of weight loss that was significant over 30/90/180 days. The decreased intakes were a contributing factor to the weight loss. She was generally not eating one to two meals daily. The interventions were as follows: super shakes three times a day, Magic Cups twice a day, 1 teaspoon of protein powder three times a day at meals, and [MEDICATION NAME]. Appropriate interventions were in place for weight maintenance if well received. Consultant FF recommended starting Med Pass 60 milliliters (ml) three times a day. On 08/05/20 at 09:33 AM, Administrative Nurse E, revealed the process for nutritional monitoring was that the Dietary Manager and the Registered Dietician had weekly meetings and recommendations then they were given to the director of nursing, then passed on to the unit managers. The nurse or the aides would report if the resident was not eating or taking supplements. The Magic Cups were asked for from the kitchen. The nursing staff had access to the shakes in a mini fridge off the dining room area. The protein powder ordered with food was put it in the food for the resident by the dietary staff. She was not aware if anyone monitored the accuracy of the direct care staff documentation of meals and supplements percentages. Furthermore, Administrative Nurse E revealed she was not aware that R21 disliked the Magic Cups. The Magic Cup documentation should not have been documented as 0-25% on 08/04/20, as it was not refused if it was not offered. The staff should document that as not applicable. On 08/06/20 at 03:18 PM, Administrative staff A, confirmed that there was a system failure with serving of the supplements and the documentation process of meals and supplements. On 08/06/20 at 03:36 PM, Consultant GG, revealed after a significant weight loss occurs, she reviewed the record. When weight loss was found the Dietary Manager puts them on a list for Consultant GG to review. Furthermore, she confirmed R21 was not reviewed in April, but reviewed in February and again on June 10th. Additionally, she revealed she had not observed the meal tray pass service since 03/13/20. When a diet order is received, the Dietary Manager prints the tray ticket, the cook followed the tray ticket, and supplements should be written on the tray ticket. The protein powder was done by the kitchen staff. The residents likes/dislikes were monitored by the dietary manager and should be completed quarterly. Consultant GG confirmed she just received the weight reports for June, and it was looking like she was eating okay, but Med Pass was added to recommendations when she was reviewed yesterday. The other supplements should be discontinued if she was not taking them. The facility policy Weight monitoring program, undated, directed that all residents with patterned or significant weight change will be assessed as indicated. Interventions to address nutritional issues will be initiated and incorporated into the resident's care plan and re-evaluated on a timely and periodic basis. The facility procedure Significant Weight Loss/Gain, undated, revealed it is the policy of the facility to provide appropriate nutritional interventions to residents who have experienced a significant weight change. A significant weight change is identified as a weight loss or gain of five percent in one month or 10 percent in six months. A report should be generated identifying all residents with a significant weight change. Nursing staff should initiate a weight variance on each identified resident. The Registered Dietician should make recommendations for nutritional interventions based on the information provided by the nursing staff. Registered Dietician recommendations should be reviewed and initiated by the

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F 0692 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 10) nursing staff. The facility procedure Snacks and Supplements, undated, revealed that supplements should be provided to residents with special needs, if deemed necessary, or by resident's request. Supplements should be provided for residents at nutritional risk, by resident request, or as ordered by the medical doctor. Nursing staff should offer residents supplements at ordered times. The facility failed to monitor and to ensure that R21, who experienced significant weight loss, received supplements as ordered and directed in the care plan. Furthermore, the facility failed to accurately document oral intake, to monitor and assess appropriate interventions in attempt to prevent further significant weight loss.
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** The facility reported a census of 64 residents. Based on interview and record review, the facility failed to use the services of a registered nurse for at least eight consecutive hours a day, seven days a week, on two days over a holidy, to ensure the provision of adequate cares to the residents of the facility. Findings included: - Review of the facility's the posted nurse staffing hours, revealed the facility failed to provide registered nurse (RN) coverage on July 4th and 5th 2020, for the staff and residents of the facility. Interview with Licensed Nurse (LN) B, on 7/28/20 at 11:42 AM, stated that on July 4th and 5th the facility failed to provide the residents of the facility with RN coverage. Interview with Administrative Staff A, on 02/26/19 at 11:58 AM, confirmed the facility failed to provide RN coverage on July 4th and 5th of 2020, for the residents of the facility. The facility undated policy for, Nursing Staffing(NAME)Falls Extended Care shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and individual plans of care. And to ensure a registered nurse on duty at least eight consecutive hours per day. The facility failed to provide at least 8 consecutive hours of RN coverage for two days over a holiday weekend, to ensure the residents received the cares required.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 64 residents, including five residents reviewed for unnecessary medications. Based on interview and record review, the facility failed to ensure the accurate administration of a medication, Levothyroxin ([MEDICAL CONDITION] medication) as ordered by the physician for one of the five selected residents, Resident (R) 52. Findings included: - Resident (R) 52's signed physician orders, dated 06/03/2020, documented the resident admitted on [DATE], with the following [DIAGNOSES REDACTED].), dementia (progressive mental disorder characterized by failing memory, confusion), paranoid personality disorder (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear.), hypertension (elevated blood pressure), and [MEDICAL CONDITION] (condition characterized by decreased activity of the [MEDICAL CONDITION]). The admission Minimum Data Set, dated dated [DATE], revealed R52 had a Brief Interview for Mental Status (BIMS) of six, indicating severely impaired cognition. The quarterly MDS, dated [DATE], revealed the resident had a BIMS score of four, indicating severely impaired cognition. The physician's orders [REDACTED]. Review of the Medication Administration Record, [REDACTED]. Interview, on 07/30/2020 at 08:23 AM, with Licensed Nurse (LN) H, confirmed the facility staff failed to administer the medication as ordered by the physician on these five days. Interview, on 07/30/2020 at 08:39 AM, with Administrative Nurse D revealed if there was a blank spot on the Medication Administration Record, [REDACTED]. The facility policy for Medication Administration-General Guidelines, undated, documented that the authorized individual administering medication shall enter a password and username when signing. Initials of the authorized individual will be affixed to the MAR indicated [REDACTED]. The facility failed to administer this [MEDICAL CONDITION] medication as ordered by the physician on five days, for R52.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 64 residents with 23 selected for review including five residents reviewed for unnecessary medications. Based on record review and interview, the facility failed to timely act upon pharmacy recommendations in a timely manner for two of the five residents reviewed, Resident (R)31 and R48. Findings included: - The Medication Review Report, dated 06/03/2020, for Resident (R)31, included [DIAGNOSES REDACTED].). The annual Minimum Data Set (MDS), dated [DATE], assessed R31 with a Brief Interview of Mental Status (BIMS) score of 15, indicating cognitively intact. She received seven days of insulin injections, an antipsychotic (class of medications used to treat [MEDICAL CONDITION] and other mental emotional conditions), an antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), an antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), an anticoagulant (class of medications used to prevent a blood clot), and a diuretic (medication to promote the formation and excretion of urine). The quarterly MDS, dated [DATE], assessed the R31 with a BIMS of 15. She received seven days of insulin injections, an antipsychotic (class of medications used to treat [MEDICAL CONDITION] and other mental emotional conditions), an antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), an antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), an anticoagulant (class of medications used to prevent a blood clot), antibiotic (class of medications used to treat bacterial infections), and a diuretic (medication to promote the formation and excretion of urine). The Recommendations to Nursing, dated 09/26/19, revealed to evaluate medications for possible discontinuation or reduce as R31 felt she was on too many medications. The response from the physician was dated 11/19/19, 54 days after the recommendation, and ordered discontinuation of four medications. The Recommendations to Prescriber, dated 10/31/19, recommended the antibiotic that R31 received be changed from intramuscular form to oral form. The form lacked physician response. The Medication Administration Record, [REDACTED]. The facility failed to act on the recommendation timely. On 08/05/20 at 10:17 AM, Administrative Nurse E, revealed that there was not a response to the recommendation to change the antibiotic route from intramuscular to oral form. The timeframe to get returned pharmacy recommendations back is around a week. The facility policy Medication Management Program, undated, lacked instruction on the timeframe for follow up to be completed on pharmacy recommendations. The facility failed to timely act upon pharmacy recommendations for R31. - Resident (R)48's Physician Orders, dated 06/03/2020, documentation included [DIAGNOSES REDACTED]. Review of the pharmacist recommendations on the electronic medical record (EMR) and facility hard copies, dated 09/26/2019 through 06/28/2020, documentation revealed the following pharmacist recommendations, the facility failed to follow-up: 1. On 09/26/2019 at 08:11 PM, the pharmacist's drug regimen review (DRR) included current available chart data reviewed. Recommendations: see report- evaluate aspirin, [MEDICATION NAME]; see report for nursing comments The facility failed to provide report for nursing comment and follow-up. 2. On 10/30/2019 at 09:58 PM, the pharmacist DRR: current available chart data reviewed. Recommendations: see report for nursing recommendation. The facility failed to provide report for nursing comment and follow-up. 3. On 02/26/2020 at 11:57 PM, pharmacist MRR: Current available chart data reviewed. Recommendations: see report for nursing recommendation. The facility failed to provide report for nursing comment and follow-up. 4. On 04/28/2020 at 11:55 AM, the pharmacist DRR: current available chart data reviewed. Recommendations: see report for nursing recommendation. The facility failed to provide report for nursing comment and follow-up. 5. On 06/29/2020 at 10:47 AM, the pharmacist DRR: current available chart data No record of report or response reviewed. Recommendations: see report for nursing recommendations. The facility failed to provide report for nursing comment and follow-up. Review of the pharmacist recommendations on the EMR and facility hard copies dated 09/26/2019, 10/30/2019, 02/26/2020, 04/28/2020, and 06/29/2020, documentation revealed a lack of completed pharmacy recommendations follow-up. 6. On 05/28/2020 at 10:48 PM, the pharmacist DRR: currently available chart data reviewed. Recommendations: see report for

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F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 11) nursing recommendation documentation included to discontinue as needed (prn) not used in 30 days for [MEDICATION NAME] (medication for nausea/vomiting). On 07/29/2020 at 10:27 AM, Licensed Nurse (LN) K reported the pharmacist reviewed the resident's medication regimen monthly. The unit manager tracked the pharmacist recommendations. She reported that the resident had multiple changes in her medications. On 08/04/2020 at 04:45 PM, LN G, upon request provided the pharmacy reviews and follow-up response to the physician since the resident's admission in 09/2020. He reported the pharmacist recommendations provided were all he and the pharmacy had. He verified the facility and pharmacy did not have the pharmacy recommendations for 09/26/2019, 10/30/2019, 02/26/2020, 04/28/2020, and 06/29/2020. Additionally, he verified the pharmacist review for 05/28/2020, lacked a response from the physician until 14 days after the recommendation. LN G stated he was responsible for tracking pharmacy recommendations and physician response for the resident and the physician response should be no later than seven to 10 days after the recommendation. On 08/05/20 at 01:41 PM, Administrative Nurse D reported the pharmacist reviewed the resident's medication regimen monthly and made recommendation. Her expectation was that the designated staff member should organize and track the pharmacist recommendation to ensure follow-up to ensure a monthly review was completed and the response to the recommendations should be within seven days of receiving the recommendation. She would expect the pharmacist to identify irregularities and report irregularities to the facility and doctors. On 08/12/2020 at 05:08 PM, the pharmacist was unavailable for interview. The undated policy for Medication Management Program documentation included the main goal of improving the performance of medication management process is to continuously improve resident health outcomes and reduce the occurrence of related medication errors and medication related adverse resident outcomes including adverse drug reactions. The policy did not address the timeliness of the physician's response to the pharmacist recommendations. The facility failed to ensure the pharmacist monthly medication review identified and reported irregularities to the director of nursing and physician. The facility failed to ensure the pharmacist's recommendations received a timely response for the resident.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 64, with 23 residents sampled, which included five residents sampled for unnecessary medications. Based on interview and record review, the facility failed to accurately monitor two of the five sampled residents' medications to ensure no unnecessary medication usage, with the failure to accurately monitor the blood pressure and pulse parameters for the two residents (R) 52 and R48, who received hypertensive medications. Findings included: - Resident (R) 52's signed physician orders, dated 06/03/2020, documented the resident admitted on [DATE], with [DIAGNOSES REDACTED]. The admission Minimum Data Set, dated dated [DATE], revealed R52 had a Brief Interview for Mental Status (BIMS) of six, indicating severely impaired cognition. The quarterly MDS, dated [DATE], revealed the resident had a BIMS score of four, indicating severely impaired cognition. The physician's orders [REDACTED]. Hold the medication for a pulse less than 60. Notify the primary care physician (PCP) for blood pressure less than 90/40 or greater than 180/115 or pulse less than 60 for 3 consecutive days or a pulse greater than 130. Review of the Medication Administration Record [REDACTED]. On 07/15/2020 with a blood pressure 132/67 and pulse of 57. On 07/17/2020 with a blood pressure of 129/78 and a pulse of 57. On 07/24/2020 with a blood pressure of 153/84 and a pulse of 56. Interview on 07/30/2020 at 08:35 AM, with Certified Medication Aide (CMA) who confirmed R52's pulse was outside of the physician ordered monitoring parameters and the staff should have held the resident's blood pressure medication, per the physician's orders [REDACTED]. The nurse should have been notified. The medication was administered to the resident anyway. Interview on 07/30/2020 at 08:39 AM, with Administrative Nurse D, confirmed the staff administered the medication and the staff should hold the medication if the blood pressure/pulse were outside of the physician ordered parameters. The facility's policy, Medication Administration-General Guidelines, undated, documented if a medication requires monitoring of BP, Pulse, FBS before administration, the person administering the med will perform the required monitoring before administration. If there are hold parameters, the monitoring information will be compared to parameters and medication will be administered or held. If held, nurse will be notified and document. The facility failed to adequately monitor the resident's pulse on four occasions when the pulse was outside of the ordered parameters, to ensure no unnecessary mediation usage for this resident who received medication for hypertension. - Review of Resident (R)48's Physician Orders, dated 06/03/2020, documentation included [DIAGNOSES REDACTED]. Physician order, dated 04/09/2020, instructed the staff to administer [MEDICATION NAME] Tablet 2.5 mg (milligrams), give one tablet by mouth, daily for [MEDICAL CONDITION], Hold and call primary care physician (PCP) for blood pressure (BP) less than 110/60 and pulse is less than 60. Review of the residents Medication Administration Record [REDACTED]. Review of the nurses notes on those dates revealed a lack of documentation related to the reason the medication was not given and/or a physician notification. Review of the residents MAR, dated 07/2020, documentation revealed an out of parameter BP of 90/58, on 07/06/2020. The medication coded as ON. Review of the nurses notes for that date lacked documentation of notification of the physician for the out of parameter BP nor if the medication was held. On 07/28/2020 at 11:50 AM, the resident communicated with gestures because she could not talk. She gestured with her head and hand to answer yes and no questions. The resident indicated the staff provided her medications and monitored her blood pressure and she was not aware of any concerns with the administration of her medications. On 07/30/2020 at 08:18 AM, Certified Medication Aide (CMA) T stated that BPs should be reported to the nurse when they were out of the physician ordered parameters. The medication aide would wait for instructions from the nurse before giving the medication and any physician notifications should be done by the nurse. 07/30/20 09:17 AM, Administrative Nurse E, stated the medication aide should report BPs to the nurse when they were out of parameters. The medication aide should wait for instructions from the nurse before giving the medication. The nurse should verify the BP and document any physician notifications in the nurses' notes. On 08/04/20 at 10:20 AM. Licensed Nurse (LN) J reported the CMAs give medications taken by mouth. Any BPs out of parameter and any medications should be reported to the nurse who should follow-up and direct the CMA what further action should be taken. The physician should be notified of any held medications and documentation in the nurses' notes should reflect the occurrence. On 08/05/20 at 01:41 PM, Administrative Nurse D stated staff should administer medications as ordered and follow parameters for holding BP meds as indicated by the physician orders. She stated she expected staff to document in the nurses' notes the reason for holding medications and the notification of the physician. The undated facility policy Medication Administration-General Guidelines documentation included medications are administered as prescribed in accordance with good nursing principles and practices. If medications require monitoring of BP before administering the person administering the medication will perform the required monitoring before administration. If there are hold parameters, the monitoring information will be compared to parameters and medication will be administered or held. If held, the nurse will be notified and documented. The facility failed to monitor the resident for unnecessary medications related to the facility failure to accurately monitor the BP for this resident who received antihypertensive medication.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 64 residents. Based on observation, interview and record review, the facility failed to maintain an effective Quality Assessment and Assurance (QAA- facility meeting of key personal to identify issues with care and services in the facility and develop action plans to correct the concerned) program to ensure the residents of the facility received needed cares and services. Findings included: - On 08/06/20 at 03:38 PM, Administrative Staff A reported the Quality Assessment and Assurance Committee (QAA) met at a minimum of quarterly with the required attendees. She reported the facility's QAA Committee failed to identify the areas of deficient practice identified during the survey due to the department heads lack of accountability and her failure to provide oversight. The facility failed to provide adequate care and services to the resident's of the facility as evidenced by the following citations: 1. Refer to F-567, the facility failed to provide 14 Residents (R)59, R73, R72, R25, R39, R32, R3, R15, R70, R10, R16, R60, R30, and R68, with interest based on actual earnings or end of quarter balances, during the year of 2019. Additionally, the facility allowed three Residents, R1, R44, and R1, to have a negative balance in the pooled residents' account with the other residents. 2. Refer to F-569, the facility failed to notify three of the eight residents, Residents (R) 73, R32, and R43, when their resident accounts reached $200.00 less than the Social Security Insurance (SSI) resource limit. If the amount in the

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F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 12) resident's account, in addition to the value of the resident's other nonexempt resources, reached the SSI resource limit the resident may lose eligibility for Medicaid SSI. 3. Refer to F-583, the facility failed to provide confidentiality for two of the residents, Resident (R) 43 and R49. A post made on social media included the residents first names and a medical [DIAGNOSES REDACTED]. Refer to F-609, the facility failed to report an allegation of abuse timely for one sampled resident, Resident (R) 36. Furthermore, the facility failed to submit completed investigations for three of the sampled residents, R36, R68, and R53 regarding allegations of abuse and neglect, to the appropriate state agency within five days of the occurrences, as required. 5. Refer to F-610, the facility failed to thoroughly investigate allegations of staff to resident abuse for two of the four selected residents, Resident (R)68 and R36. 6. Refer to F-727, the facility failed to use the services of a registered nurse for at least eight consecutive hours a day, seven days a week, on two days over a holiday, to ensure the provision of adequate cares to the residents of the facility. 7. Refer to F-677, the facility failed to provide the necessary services to maintain personal hygiene for one of the two selected residents, Resident (R) 52 related to grooming of chin hairs. 8. Refer to F-689, the facility failed to implement new and appropriate interventions following falls to prevent further falls for one of the three residents, Resident (R)21. 9. Refer to F-690, the facility failed to provide the necessary treatment and services regarding catheter care for Resident (R) 43, to prevent urinary tract infection. 10. Refer to F-692, the facility failed to provide and monitor interventions to prevent significant weight loss for Resident (R)21, who experienced a significant weight loss of 5.17 percent in one month and 16.3 percent in six months. 11. Refer to F-755, the facility failed to ensure the accurate administration of a medication, Levothyroxin ([MEDICAL CONDITION] medication) as ordered by the physician for one of the five selected residents, Resident (R) 52. 12. Refer to F-880, the facility failed to provide appropriate use of personal protective equipment (PPE) to prevent cross contamination and prevent the spread of infection for two the three COVID-19 residents, Residents (R)35 and R 49, to the residents of the facility. Furthermore, the facility failed to maintain an effective infection control program with the failure to ensure appropriate sanitary process for the safe and aseptic handling and storage of linen to prevent cross contamination from R69 and prevent the spread of infection for the residents of the facility. The facility policy for, QAPI Plan and Program, dated 02/2020, documentation included the purpose of the quality assurance and performance improvement (QAPI) in our organization was to take a proactive approach to continually improving the way we care for and engage with our residents. The facility failed to identify issues with the care and services provided to the residents of the facility and failed to implement an effective action plan to correct those issue.
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** The facility reported a census of 64 residents with 23 residents sampled. The facility reported three residents with active COVID-19. Based on observation, interview and record review, the facility failed to provide appropriate use of personal protective equipment (PPE) to prevent cross contamination and prevent the spread of infection for two the three COVID-19 residents, Residents (R)35 and R 49, to the residents of the facility. Furthermore, the facility failed to maintain an effective infection control program with the failure to ensure appropriate sanitary process for the safe and aseptic handling and storage of linen to prevent cross contamination from R69 and prevent the spread of infection for the residents of the facility. Findings included: - Review of Resident (R)35's Physician Orders, dated 06/03/2020, revealed documentation included [DIAGNOSES REDACTED]. The annual Minimum Data Set ((MDS) dated [DATE] documented the resident with the Brief Interview for Mental Status (BIMS) score of 14, which indicated cognitively intact. He was totally dependent on staff for transfers. He required extensive assistance of staff for bed mobility, toilet use and personal hygiene. The resident had functional limitation in range of motion with the lower extremities on both sides. He had a feeding tube and mechanically altered diet. The care plan (CP) in the electronic medical record (EMR), dated 06/02/2020, lacked revision of care guidance to the staff regarding strict quarantine due to his positive COVID-19 test received by the facility on 07/24/2020. Review of the resident's Miscellaneous Tab in the EMR, dated 07/24/2020, revealed the resident tested positive for COVID-19 from a nasal swab specimen collected on 07/23/2020. On 07/25/2020 at 08:20 PM, a Health Status Note in the EMR, documented personal protective equipment (PPE) supplies were set up for use in care of the resident. Staff were already wearing mandated masks and gloves. On 08/03/2020 at 07:40 AM, a Health Status Note in the EMR, documented the resident continued with isolation for positive COVID-19 test, with lung sounds diminished but clear, and no cough noted at time of the assessment. On 07/30/2020 at 09:17 AM, Administrative Nurse E reported the residents that test positive for COVID-19 were immediately placed in strict isolation/quarantine, which included isolation set up outside of their rooms that included gloves, gowns, N95 masks, shoe covers and face shields. She reported the staff received training regarding the proper use of PPE. On 08/03/2020 at 10:40 AM, Certified Nurse Aide TT stated that the residents with active COVID had dedicated staff to provide care. She reported that enhance precautions were in affect for the three resident that tested positive for COVID. The precautions included an isolation cart in hallway, which contained masks, gloves, booties, gowns, and goggles. On 08/04/2020 at 09:04 AM, CNA Q reported the resident was on COVID precautions and he had dedicated staff to take care of him. She reported she did not go into his room. CNA VV does not take care of anyone other than the three active COVID-19 residents. On 08/04/2020 at 03:53 PM, CNA VV sanitized his hands, applied gloves, and gown. He wore a regular mask and indicated that just inside the resident's room door was where he left his N95 mask by the door inside the room to prevent overuse of N95 masks. He opened the door to the room and pointed to a N95 mask laying directly on an overbed table in the resident's bathroom. The mask was not covered or stored in a brown bag while not in use and there was not a barrier between the mask and the surface of the table. Additionally, CNA VV, failed to put on a face shield and/or shoe covers stating they were not available in the residents PPE isolation set up. He verified that he had not informed anyone of the lack of face shields or shoe covers. On 08/05/2020 at 05:10 PM, Licensed Nurse (LN) G, verified the presence of shoe covers and face shields in the residents PPE set up. LN G stated he was not aware of any reports regarding the staff needing any PPE supplies. On 08/05/2020 at 05:15 PM, Administrative Nurse D stated she would expect staff to wear appropriate PPE when providing care to a resident quarantined due to a positive COVID-19 test. She confirmed that appropriate PPE should include gloves, gown, N95 masks, shoe covers and face shield. The facility policy Infection Control and Prevention, dated 02/2020, documentation included the infection control and prevention program is part of the facility's goal of providing the best possible care to its residents and a safe workplace for personnel. Effective infection control and prevention management also assists the facility to optimize resources by decreasing nosocomial (facility acquired) infections in residents or personnel. The facility policy Novel Coronavirus (2019-nCOV) (COVID-19), dated 07/15/2020, documentation instructed the residents suspected of COVID-19 will have transmission-based precautions immediately including wearing appropriate PPE which includes gloves, gowns, masks, and eye protection. The facility failed to ensure appropriate application and storage of PPE to prevent cross contamination and the spread of infection to the residents of the facility related to the resident who tested positive for COVID-19. - On 07/27/20 at 02:14 PM, Resident (R)69 sat in her wheelchair, her bed lacked linens, sheets, bedspread, and pillow which was all piled on top of the dresser and hanging directly down and onto the floor. On 07/27/20 at 02:14 PM, Certified Nurse Aide (CNA) LL confirmed the above observation and removed the soiled linens. She stated she had not stripped the resident's bed or placed the soiled used linen on the dresser. CNA LL explained that the off going staff at 06:00 AM, that morning pulled the linens off from the resident's bed. She stated the linen should have been removed from the room and not be in direct contact with the floor to prevent cross contamination and prevent spread of infections. On 07/30/20 at 09:17 AM, Administrative Nurse E stated soiled bedding placed on top of the dresser was not acceptable. The resident did not put it there, the staff had to place it on the dresser. She stated she expected the staff to keep the residents' house clean, prevent cross contamination and prevent infections. On 08/05/20 at 09:07 AM, Administrative Nurse D stated staff should contain and remove soiled linen from the rooms when stripping the beds to prevent cross contamination and prevent infection. The facility policy Infection Control and Prevention, dated 02/2020, documentation included the infection control and prevention program is part of the facility's goal of providing the best possible care to its residents and a safe workplace for personnel. Effective infection control and prevention management also assists the facility to optimize resources by decreasing nosocomial (facility acquired) infections in residents or personnel. The facility failed to provide an appropriate sanitary process for the safe and aseptic handling and storage of linen to prevent cross contamination and the spread of infections to the residents of the facility. - The progress note, dated 07/19/20, for Resident (R)49, revealed nares were swabbed for COVID-19. The progress note, dated 07/23/19, revealed R49 continued with isolation precautions due to a positive COVID-19 test. The care plan, initiated on 07/20/20, lacked information regarding COVID-19 status and how to provide care related to this problem. On 08/03/20 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175520	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VICTORIA FALLS	**224 E CENTRAL ANDOVER, KS 67002**

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 13) 12:15 PM, R49 was hollering out and Certified Nurse Aide (CNA) PP stationed outside of the room, opened the door to the room and informed R49 she would suit up and be in. CNA PP placed on gloves, shoe covers, gown, and then placed a n95 mask over the mask she already had in place. Then, CNA PP applied a face shield just inside at the entry way to the resident's room. On 08/03/20 at 12:25 PM, CNA PP revealed that there were three face shields available inside the room that staff shared. She used the same one during her shift and cleansed the shield after use with alcohol wipes. Furthermore, she revealed that she received training on what PPE (personal protective equipment) to wear by the facility and that it was okay to place the n95 mask over the other previously worn mask. On 08/06/20 at 02:33 PM, Administrative Nurse D reported that the chemical Virex should be used to disinfect the face shields, not alcohol wipes, and staff are not to put the n95 mask over the surgical mask. The facility policy COVID-19, revised 07/15/20, directed the staff to wear appropriate PPE including but not limited to gloves, gown, mask, and eye protection. The policy directed staff to use respiratory protection before entry into the room or care area and to remove it before leaving and discard. The policy failed to direct the type of face mask to be used. The policy included that reusable eye protection must be cleaned and disinfected prior to re-use. The policy failed to include direction on what product to use to clean and disinfect. The facility failed to ensure that staff used PPE appropriately and cleaned it appropriately after being used to care for a resident with COVID-19, to prevent the spread of infection to the residents of the facility.