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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of complaint investigation #138098.<br><br>This 2567 was electronically sent to the facility on 3/19/19. | F 000 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced | F 609 | | |

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

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| F 609 | Continued From page 1 | F 609 | | |

by:
The facility reported a census of 61 residents, with 3 selected for review. Based on interview and record review, the facility failed to report to the state agency as required, 1 incident of neglect, for 1 (#2) of the 3 sampled residents, when the resident attempted to remove another resident from (#2's) bed, and experienced a fall which resulted in a fractured wrist.

Findings included:

- Resident # 2 admitted to the facility, on 8/11/17 with diagnoses including vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) and abnormality of gait, per the 1/14/19 physician order.

The 6/1/18 annual MDS (minimum date set) identified the resident with severe cognitive impairment. The resident required extensive assist with dressing, toileting, and personal hygiene. The resident had no functional range of motion impairment, used no devices for mobility, and experienced no falls since the prior MDS.

The 6/1/18 cognitive CAA (care area assessment) documented the resident was not oriented to time, did not respond to name, and had poor memory. He/she had poor safety awareness and impulsivity.

The 6/1/18 fall CAA, documented the resident had a history of falls, poor safety awareness, impulsivity, and continued at a risk for falls. The care plan was to address safety and provide interventions to reduce the resident's risk of falls

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| F 609 | Continued From page 2 | F 609 | | |

and /or injury.

The 1/21/19 quarterly MDS documented the resident's cognition as severely impaired and the resident experienced 2 non-injury falls since the prior MDS.

The 1/15/19 care plan instructed staff to keep the call light kept within reach. He/she ambulated independently without devices, initiated 11/21/17. Additions on:
7/23/18, resident to be put into bed.
8/28/18, resident to be encouraged to lay in bed not recliner.
9/24/18 staff to assist resident with getting ready for AM.
11/8/18, fall in room. Recliner unplugged at night.
11/11/18, Dycem (non-slip material) in the recliner.
However, the care plan lacked an intervention following the fall on 1/22/19, when the resident fractured his/her wrist.

The nurses' notes dated 1/22/19 at 5:10 PM, documented the staff found the resident lying on the floor in his/her room next to the wall. The resident reported he/she did hit his/her left wrist on the wall. Staff noted swelling to the resident's left wrist, and tenderness with grips. The resident explained he/she was trying to remove another resident from his/her bed and fell over.

An X-ray report, dated 1/22/19, of the left forearm revealed a fractured wrist.

On 3/13/19 at 11:52 AM, direct care staff I was in the resident's room, talking to the resident who walked around the room, holding 2 briefs in his/her hands and then walked with staff I into the

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| F 609 | Continued From page 3 | F 609 | | |

shower room. Staff I assisted him/her to pull down his/her pants. The resident wore a brace on his/her left wrist. Following toileting the resident walked to the dining room, unassisted by staff.

On 3/13/19 at 12:10 PM, direct care staff I reported the resident ambulated ad lib without any devices, and reported the staff kept an eye on him/her, but staff I was not sure what the new intervention was after the fall to prevent further falls for the resident.

On 3/13/19 at 1:40 PM, direct care staff K reported we watch all of our people here in the unit closely, and did not think we do anything different, for him/her, since the cast came off.

On 3/13/19 at 4:00 PM, administrative staff A reported he/she reviewed the fall and wrote on the investigation that the resident was alone in his/her room and, and the facility felt there was no abuse or neglect substantiated, so the incident was not reported to the state agency. Staff A explained the facility staff did not feel the incident required reporting to the state agency. Administrative staff A reported to his/her knowledge there was not another resident in the bed, the resident just thought there was.

The 1/25/19 investigation for the fall, included a written statement by direct care staff G which documented he/she saw the resident at 3:55 PM, while passing gowns and the resident was standing by the closet. Staff G did not witness the fall. The facility's investigation lacked a witness statement from the charge nurse at the time of the fall.

On 3/15/19 at 11:15 AM, licensed nursing staff D

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| F 609 | Continued From page 4 | F 609 | | |

reported any resident from the unit that had a fall had to have neuro-checks if the fall was un-witnessed. He/she reported the resident went to the hospital, he/she started neuro checks on the resident, and further verified that at the time of the incident, there was another resident in this resident's bed.

The 2/2018 facility policy for Protection of Residents: Reducing the Threat of Abuse and Neglect documented as follows: The definition of neglect: means the failure of the facility, its employees or service providers to provide goods and services to a resident to avoid physical harm, pain, mental anguish or emotional distress. It is the policy and practice of this facility that all residents will be protected from all types of abuse, neglect, misappropriation of resident property, and exploitation ... Assure that residents are free from neglect by having the structures and processes to provide needed care and services to all residents, which includes, but not limited to, the provision of a facility assessment to determine what resources are necessary to care for its residents competently. Facilities must satisfy the federal requirement to report the results of an investigation within 5 working days from the date of the incident (or knowledge of the incident). Any report after that time will be considered out of compliance with the regulation.

The facility failed to report this incident of neglect to the state agency as required, when staff failed to provide adequate monitoring of another resident, who was in this confused resident's bed. This confused resident tried to remove the other resident from his/her bed, fell and experienced a fractured wrist.

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| F 657 | Continued From page 5 | F 657 | | |
| F 657 SS=D | Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 61 residents, with 3 sampled for review. Based on observation, interview, and record review, the facility failed to review and revise the plan of care for 1 (#2) of the 3 sampled residents, related to new interventions following a fall by the resident who was attempting to remove another resident from | F 657 | | |

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| F 657 | Continued From page 6 | F 657 | | |

his/her bed.

Findings included:

- Resident # 2 admitted to the facility, on 8/11/17, with diagnoses including vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) and abnormality of gait, per the 1/14/19 physician order.

The 6/1/18 annual MDS (minimum date set) identified the resident with a BIMS (brief interview for mental status) score of 4, indicating severe cognitive impairment. The resident required extensive assist with dressing, toileting, and personal hygiene. The resident experienced no limits in functional range of motion ability, used no devices for mobility and had no falls since the prior MDS.

The 6/1/18 cognitive CAA (care area assessment), documented the resident was not oriented to time, did not respond to name, and had poor memory. He/she had poor safety awareness and impulsivity.

The 6/1/18 fall CAA, documented the resident had a history of falls, poor safety awareness, impulsivity and continued at risk for falls. The care plan was to address safety and provide interventions to reduce the resident's risk of falls and/or injury.

The 1/21/19 quarterly MDS, documented the resident's cognition was severely impaired and the resident experienced 2 non-injury falls since the prior MDS.

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| F 657 | Continued From page 7 | F 657 | | |

The 1/15/19 care plan, instructed staff to keep the resident's call light kept within reach.
He/she ambulated independently without devices, initiated 11/21/17.
Additions on:
7/23/18, resident to be put into bed.
8/28/18, resident to be encouraged to lay in the bed, not in the recliner.
9/24/18 staff to assist resident with getting ready for AM.
11/8/18, fall in room. Recliner unplugged at night.
11/11/18, Dycem (non-slip material) in the recliner.
However, the resident's care plan lacked an intervention, following the resident's fall on 1/22/19, when the resident fell and fractured his/her wrist. The resident reported at the time, he/she was trying to get another resident out of his/her bed, causing the fall.

The nurses' notes, dated 1/22/19 at 5:10 PM, documented the staff found the resident lying on the floor in his/her room next to the wall. The resident reported he/she hit his/her left wrist on the wall. Staff noted swelling to the resident's left wrist, and tenderness with hand gripping. The resident explained he/she was trying to remove another resident from his/her bed and fell over.

On 3/13/19 at 11:52 AM, direct care staff I was in the resident's room, talking to the resident, who walked around the room, holding 2 briefs in his/her hands and then walked with staff I into the shower room. Staff I assisted him/her to pull down his/her pants. The resident wore a brace on his/her left wrist. Following toileting, the resident walked to the dining room, unassisted by staff.

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| F 657 | Continued From page 8 | F 657 | | |

On 3/13/19 at 12:05 PM, the resident explained with questioning why he/she wore the wrist brace. The resident commented he/she hurt it, wore the brace all of the time because it made it better.

On 3/13/19 at 12:10 PM, direct care staff I reported the resident ambulated ad lib without any devices, and reported the staff kept an eye on him/her but was not sure what the intervention was after the fall.

On 3/13/19 at 1:40 PM, direct care staff K reported we watch all of our people here in the unit closely, and don't think we do anything different, for him/her, since the wrist cast came off.

On 3/15/19 at 11:15 AM, licensed nursing staff D reported any resident from the unit that had a fall had to have neuro-checks if the fall was un-witnessed. He/she reported the resident went to the hospital and staff D did start neuro checks on the resident. Staff D verified that there had been another resident in the resident's bed at the time of the resident's fall.

On 3/15/19 at 11:30 AM, administrative nursing staff R verified the care plan lacked an intervention following the fall on 1/22/19. He/she reported the intervention was to check on the resident frequently.

On 3/15/19 at 2:20 PM, administrative staff A explained that an intervention needed included following each resident's fall and then verified that just adding frequent checks on a resident who fell was too vague to be adequate.

The undated facility policy for, falls management,

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| F 657 | Continued From page 9<br>documented the facility must ensure the residents' environment remained as free of accident hazards as possible and each resident received adequate supervision and assistance devices to prevent accidents.<br><br>The facility failed to identify the root cause of the resident's fall, when the resident was trying to get another resident out of his/her bed, causing a fall by the resident. The facility failed to implement new interventions to prevent further falls by the resident. | F 657 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 61 residents, with 3 sampled and reviewed for accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision and/or assistive devices to prevent further falls for 1 (#2) of the 3 sampled residents, when the facility failed to identify the root cause and implement interventions to prevent further falls, after the resident attempted to get another resident out of his/her bed, fell and sustained a fractured wrist.<br><br>Findings included: | F 689 | | |

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| F 689 | Continued From page 10 | F 689 | | |

- Resident # 2 admitted to the facility, on 8/11/17, with diagnoses including vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) and abnormality of gait, per the 1/14/19 physician order.

The 6/1/18 annual MDS (minimum date set) identified the resident with a BIMS (brief interview for mental status) score of 4, indicating severe cognitive impairment. The resident required extensive assist with dressing, toileting, and personal hygiene. The resident experienced no limits in functional range of motion ability, used no devices for mobility and had no falls since the prior MDS.

The 6/1/18 cognitive CAA (care area assessment), documented the resident was not oriented to time, did not respond to name, and had poor memory. He/she had poor safety awareness and impulsivity.

The 6/1/18 fall CAA, documented the resident had a history of falls, poor safety awareness, impulsivity and continued at risk for falls. The care plan was to address safety and provide interventions to reduce the resident's risk of falls and /or injury.

The 1/21/19 quarterly MDS, documented the resident's cognition as severely impaired and the resident experienced 2 non-injury falls since the prior MDS.

The 1/15/19 care plan, instructed staff to keep the resident's call light kept within reach.

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The resident was at risk for falls, with a history of falls, poor safety awareness, and poor cognition. He/she ambulated independently without devices, initiated 11/21/17.
Additions on:
7/23/18, resident to be put into bed.
8/28/18, resident to be encouraged to lay in the bed, not in the recliner.
9/24/18 staff to assist resident with getting ready for AM.
11/8/18, fall in room. Recliner unplugged at night.
11/11/18, Dycem (non-slip material) in the recliner.
However, the resident's care plan lacked an intervention, following the resident's fall on 1/22/19, when the resident fell and fractured his/her wrist.

The 1/22/19 fall risk assessment, scored -13 with anything above a 10 being at risk for falls.

The nurses' notes, dated 1/22/19 at 5:10 PM, documented the staff found the resident lying on the floor in his/her room next to the wall. The resident reported he/she did not hit his/her head but did hit his/her left wrist on the wall. Staff noted swelling to the resident's left wrist, and tenderness with hand gripping. The resident explained he/she was trying to remove another resident from his/her bed and fell over.

An X-ray report, dated 1/22/19, of the resident's left forearm, revealed a fractured wrist.

On 3/13/19 at 11:52 AM, direct care staff I was in the resident's room, talking to the resident, who walked around the room, holding 2 briefs in his/her hands and then walked with staff I into the shower room. Staff I assisted him/her to pull

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down his/her pants. The resident wore a brace on his/her left wrist. Following toileting, the resident walked to the dining room, unassisted by staff.

On 3/13/19 at 12:05 PM, the resident explained with questioning why he/she wore the wrist brace. The resident commented he/she hurt it, wore the brace all of the time because it made it better.

On 3/13/19 at 12:10 PM, direct care staff I reported the resident ambulated ad lib without any devices, and reported the staff kept an eye on him/her but was not sure what the intervention was after the fall.

On 3/13/19 at 1:40 PM, direct care staff K reported we watch all of our people here in the unit closely, and don't think we do anything different, for him/her, since the wrist cast came off.

On 3/15/19 at 11:15 AM, licensed nursing staff D reported any resident from the unit that had a fall had to have neuro-checks if the fall was un-witnessed. He/she reported the resident went to the hospital and staff D did start neuro checks on the resident. Staff D verified that there had been another resident in the resident's bed at the time of the resident's fall.

On 3/15/19 at 11:30 AM, administrative nursing staff R verified the care plan lacked an intervention following the fall on 1/22/19. He/she reported the intervention was to check on the resident frequently.

On 3/15/19 at 2:20 PM, administrative staff A explained that an intervention needed included following each resident's fall and then verified that

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175373 | A. BUILDING _____ B. WING _____ | C 03/13/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF BURLINGTON | 601 CROSS STREET BURLINGTON, KS 66839 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 13 | F 689 | | |

just adding frequent checks on a resident who fell was too vague to be adequate.

The undated facility policy for, falls management, documented the facility must ensure the residents' environment remained as free of accident hazards as possible and each resident received adequate supervision and assistance devices to prevent accidents.

The facility failed to identify and address the root cause of the resident's fall, i.e., another resident in the bed and the resident attempting to remove the other resident, to prevent repeated falls. The resident fell trying to remove the other resident from his/her bed.