STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175302	A. BUILDING _____ B. WING _____	C 02/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWTON PRESBYTERIAN MANOR	**1200 E 7TH STREET NEWTON, KS 67114**

(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 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #159628, 159829, 160033. The 2567 was electronically sent on 02/12/21.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 39 residents with four residents sampled, including one resident reviewed for accidents. Based on observation, interview, and record review the facility failed to provide safe bathing opportunities when staff left Resident (R)1unattended in the shower, which resulted in a fall that caused a fracture to the resident's left hip. Findings included: - The "Physician Order Sheet" (POS), dated 02/06/21, documented R1 had diagnoses which included: dementia (progressive mental disorder characterized by failing memory, confusion), dizziness (the sensation of spinning around and losing one's balance), unsteadiness (liable to fall), and weakness.	F 689		

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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The "Admission Minimum Data Set" (MDS), dated 10/14/20, documented the resident had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. He required limited assistance of one staff for transfers and walking in his room. His balance was not steady, and he was only able to stabilize with staff assistance. He had no limitation in his functional range of motion (ROM) and used a walker as a mobility device. He did not have any falls documented since admission to the facility..

The "Care Area Assessment (CAAs) for Falls", dated 10/14/20, documented the resident had a history of falls before his admission and required supervision to limited assistance of staff with things that would put him at an increased risk for falling. He had diagnoses of weakness and unsteadiness which could impact his risk for falls.

The "Care Area Assessment" (CAA) for "Activities of Daily Living (ADL) Functional/Rehabilitation Potential", dated 10/14/20, documented the resident had a diagnosis of dementia and a history of falling. He had functional decline which could put him at a high risk for falls.

The quarterly "MDS," dated 01/12/21, documented the resident had a BIMS score of 15, indicating intact cognition. He required supervision with set up help for ADLs and bathing and had no functional impairment in ROM. He had one fall with injury (except major) since his prior assessment.

The "Cognition Care Plan" dated 02/09/21 instructed staff the resident had an alteration in his thought processes due to a diagnosis of dementia.

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The "ADL Care Plan" dated 02/09/21 instructed staff the resident required limited to extensive assistance of one to two staff with ADLs and he preferred showers.

The "Falls Care Plan" dated 02/09/21 instructed staff the resident was at risk for falls due to a diagnosis of dementia. He also had a history of falls due to vertigo (dizziness).

Review of the resident's "Electronic Medical Record" (EMR), revealed fall assessments, dated 01/09/20 and 10/22/20, which placed the resident at a moderate risk for falls.

Review of the resident's EMR, under the "ID Notes" dated 01/27/21 revealed the resident experienced a fall while he was in the shower. Staff summoned Licensed Nurse (LN) G to the shower room. When LN G entered the shower room, she observed the resident on the floor. The resident laid naked on his left side propped on his left elbow with his right hand holding onto the handrail on the back wall of the shower area. The shower area floor was wet. When LN G asked the resident what happened, the resident responded that he did not know. LN G noted a hematoma (a solid swelling of clotted blood within the tissues) and abrasion (an area damaged by scraping or wearing away) to the resident's forehead and sheared skin on the back of his head. Certified Nurse Aide (CNA) M and Certified Medication Aide (CMA) M assisted the resident to a standing position after drying the wet shower area floor. The resident gasped in pain and informed LN G that his left hip hurt. LN G noted an abrasion to the resident's left hip. Staff assisted the resident to the shower chair, dried

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him, and dressed him. Staff then transferred the resident to the wheelchair and transported the resident to his room. LN G contacted the resident's physician and received an order to send him to the emergency room (ER) for an evaluation.

Review of the resident's EMR, dated 01/27/21 revealed the resident admitted to the hospital with a diagnosis of a fractured left hip.

Review of the resident's x-ray report dated 01/27/21 included: Probable left femoral neck fracture (fracture of the left hip).

Review of the hospital discharge papers dated 02/05/21 included a discharge diagnosis of left femoral neck fracture post intertrochanteric repair (pinning between the greater trochanter and lesser trochanter), completed on 01/28/21.

On 02/09/21 at 04:03 PM CNAs O and N transferred the resident from his bed to the recliner with the use of the sit to stand lift (a mechanical lift). Staff attached the lift sling to the resident and raised him in the lift to a standing position. The resident was able to bear weight on both legs and was able to hold on firmly to the handles of the lift.

On 02/09/21 at 04:03 PM CNA N stated before the resident fell in the shower room, he had been able to walk independently with the use of a cane or a walker.

On 02/10/20 at 10:13 AM CNA M stated she had been giving the resident his shower at the time of the fall. CNA M stated she told the resident to stay seated in the shower chair as she got some

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towels. CNA M turned her back to obtain the towels from around the corner. CNA M stated she only turned her back for a second to get the towels, but when she turned back around she saw the resident falling to the floor and she was unable to get to the resident in time to break his fall.

On 02/10/21 at 10:51 AM CMA S stated CNA M called for help when the resident fell, and CMA S responded to the shower room with the vitals machine. CMA S stated, when she got to the shower room, the resident was on the floor, naked. The shower mats were on the floor next to the resident's feet and the shower chair had been pulled out. CNA M knelt down next to the resident. The resident complained of pain in the left hip area. When LN G came into the shower room, staff sat the resident up and he continued to complain of a lot of pain. The nurse assessed the resident and staff transferred him from the floor to the shower chair, where they dried and dressed him. Staff then transferred him from the shower chair to his wheelchair. He could barely bear weight, which was unusual for him. Staff then transported the resident to his room in the wheelchair and the nurse called the Emergency Medical Services (EMS).

On 02/10/21 at 10:57 AM LN G stated a staff member told her the resident had fallen in the shower room. The resident was on the floor on his left side, holding onto the handrail with his right hand and propped on his left elbow. The floor around the resident was wet. Staff set the resident up to a sitting position on the floor and he complained of left hip pain. LN G stated the resident had a hematoma and/or abrasion to the left hip at that time. Staff transferred the resident

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to the shower chair where he was dried and dressed and then transferred to his wheelchair and taken back to his room. The resident continued to complain of pain, so LN G stated she got an order to send the resident to the hospital for an evaluation. The hospital called back later and said the resident was being admitted for a left hip fracture.

On 02/10/21 at 01:22 PM Administrative Nurse D stated the fall occurred when the CNA turned to get more towels to dry the resident following his shower. Staff are discouraged from turning their backs on a resident while they are in a shower chair.

The facility policy for "Bathing", undated, included: Staff should collect needed items before starting the procedure.

The facility failed to keep R1 safe from harm when the CNA turned her back to him to obtain more towels following his shower. This resulted in the resident attempting to stand on his own on the wet shower floor and falling, which resulted in a fracture to his left hip.