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 10/30/2019

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

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F 000	INITIAL COMMENTS The following citation represents the findings of complaint investigation #146569. The 2567 was electronically sent to the facility on 11/01/19.	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 had a census of 49 with 3 reviewed for accidents.. Based on observation, interview and record review, the facility failed to provide supervision and assistive devices to ensure one of the three residents, Resident (R) 1 remained free of accidents related to failure to ensure the planned gripper socks remained on the resident. R1 fell without the gripper socks on and sustained a fractured hip. Findings included: - The unsigned "Physician Order Sheet" (POS), for Resident (R) 1, dated 10/14/19, documented the resident had the following diagnoses: fall resulting in right hip fracture (broken bone) and right hip pain (discomfort to right hip). The significant change of condition "Minimum	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/01/2019

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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Data Set" (MDS), dated 08/22/19, documented the resident's Brief Interview for Mental Status (BIMS) score as 9, indicating moderately impaired cognition. The resident's functional status documented the resident required extensive assist of 2 staff for transfer and toileting, total dependence for locomotion, and ambulation only occurred once or twice during the look back period with the assist of 2 staff.

The 08/22/19 "Cognitive Loss/Dementia Care Area Assessment" CAA, documented the resident was alert and oriented to person, time and place (x 3) with intermittent confusion. At times she had difficulty with word find, delayed speech, and word salad.

The 08/22/19 "Fall CAA," documented her impaired cognition, mood/behavior symptoms, impaired mobility, and incontinence could impact her ability to maintain balance and understand cueing. Her risk for falls could impact her ADL function and mobility. Her care plan will direct staff to provide the safest environment to prevent falls and injuries.

The fall care plan, dated 08/11/19, included to ensure the resident wore hard-soled shoes with backs during awake times and gripper socks at night. The revision, following the fall, dated 10/08/19, directed when the resident went to bed staff were to make sure the resident had the gripper socks on and not fuzzy socks.

On 08/11/19, the "Fall Risk Assessment," documented a score of 16, and identified anything over 13 as high risk for falls.

The "Physicians Order Sheet", dated 10/14/19,

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following return from the hospital documented the following orders:
Start date 10/14/19: Tylenol 325 mg; Take 2 tablets by mouth four times a day due to left hip pain.

Start date 10/14/19: Roxicodone 5 mg: Take 1 tablet by mouth every 3 hours as needed for pain.

Start date 10/14/19: Lorazepam Intensole 2 mg/mL: Take 0.5mg/0.25mL by mouth every 3 hours as needed for restlessness and agitation.

On 10/8/19, the "Fall Investigation Report" evidenced the Certified Nurse Aide, (CNA) M, reported to the Licensed Nurse (LN) G at approximately 8:00 AM she heard R1 holler and found R1 sitting on the floor in her bathroom with her legs straight out in front of her. Resident stated that she did hit her head. She complained of pain in her head and leg. Resident's right leg was turned out. DPOA (Durable Power of Attorney) notified and requested the resident be evaluated at the hospital for evaluation. The facility staff called 911 and EMS transported resident to hospital. The resident was wearing fuzzy socks. She was not wearing the non-skid per her care plan.

Review of clinical documentation on 10/14/19 recorded the resident returned from the hospital in wheelchair. She had a urinary catheter (a tube placed in the body to drain and collect urine from the bladder) and transfered with mechanical lift. She had three incisions on her right hip due to right hip fracture surgical repair from the fall on 10/8/19. Resident returned to facility with skilled services.

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On 10/29/19 at 10:20 AM, Certified Nurse Aide (CNA)M, reported that she was working at time of R1's fall. CNA M was in another resident's room and found R1 in her bathroom. She had a soft call light by her legs and attached to the arm rest of her chair. When she stood up, her call light was lit and did alert staff that she was in the bathroom. She would take herself to the bathroom frequently without asking staff for assistance. CNA M stated she did not know of a specific toileting plan for the resident. I know the resident had on fuzzy socks at the time of the fall, but I did not know that she should have had non-skid socks on per the care plan. I am aware that she does wear non-skid socks now, but not aware that she can't wear the fuzzy socks or that she does change into the fuzzy socks herself. I could see her changing her socks because she was very independent. She doesn't wait for staff to assist her with dressing, toileting or transferring most of the time.

On 10/29/19 at 9:10 AM and on 10/30/19 at 7:37 AM, Licensed Nurse G stated that the resident required stand by assist prior to the fall on 10/8/19. Staff tried to be there for all ADL's but was not always possible due to resident's independence. She did not use her call light each time that she needed assistance. She was care planned for gripper socks, however, at the time of the fall, she was wearing one fuzzy sock and the other fuzzy sock was off. The fuzzy socks were not part of the care plan. She would change her own socks after staff put on the gripper socks. She was not on a toileting plan. The staff checked on her every time they walked by about every 15-30. I don't remember the last time she was last toileted LN G reported the resident had began declining prior to the fall, with increased

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confusion, decreased alertness, and increased weakness. The resident returned on skilled services, however was unable to participate in the skilled therapy. The resident passed away on 10/23/19.

On 10/30/19 at 10:08 am, Administrative Nurse D, stated that fall investigation report indicated that the resident did have blue fuzzy socks on and the care plan intervention was for the resident to wear non-skid socks. I have been told the resident was independent, but I have not personally seen the resident change her non-skid socks to the fuzzy socks. I agree that the staff and the facility should have been making sure that the resident wore non-skid socks at all times or hard-soled shoes per the resident's care plan. We need to complete more staff teaching and awareness to ensure each resident intervention are implemented and reviewed at the beginning of each shift to assure that a resident's interventions have not changed, or new interventions have been put in place. Staff do not appear to be ensuring residents interventions are implemented.

On 10/30/19 at 8:24 am: Consultant GG, stated that the resident had been declining rapidly due to cardiac health concerns and late stages of dementia. She stated that the resident was declining nutrition, fluid intake and becoming increasing physically weaker.

The facility's dated, 3/26/19, policy, "Falls" read: Residents were identified for risk of falls and interventions implemented to reduce risk of falls.

The facility failed to ensure staff consistently implemented planned interventions for this

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F 689	Continued From page 5 cognitively impaired dependent resident, at risk for falls. Facility staff failed to ensure R1's gripper socks remained on. R1 fell without the gripper socks on and sustained a fractured hip . Furthermore, the facility failed to determine the root cause analysis of what the resident was attempting to do at the time of the fall, to prevent further falls.	F 689		