STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175385	A. BUILDING _____ B. WING _____	C 02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK	**200 SW 14TH 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
E 000	Initial Comments A Targeted Infection Control Survey/COVID-19 Focused Survey was conducted by the Kansas Department for Aging and Disability Services (KDADS) on 02/09/21 to 02/16/21. The facility was found to be in compliance with Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID 19.	E 000		
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation KS00144646:	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services	F 582		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 582	Continued From page 1 available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: The facility census totaled 92 residents with three residents reviewed for beneficiary notices. Based on record review and interview the facility failed to notify Resident (R)5 in advance of Medicare Part A (skilled) services ending on 10/14/20 per the Centers for Medicaid/Medicare Services (CMS) regulation.	F 582		

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F 582	Continued From page 2 Findings included: - Review of R5's "Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review" revealed his Medicare Part A skilled services episode started on 08/31/20 and the last covered day of Part A service as 10/14/20. Review of "Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage," (SNFABN) signed on 10/15/20 revealed R5's coverage ended 10/14/20, but the facility did not have the resident sign the form until 10/15/20. Interview with Social Services staff C on 02/11/21 at 12:31 PM revealed the SNFABN for R5 was signed by the resident a day after coverage ended, and the form should have been completed 48-72 hours before the resident coverage ended. Review of "Medicare Claims Processing Manual," revised 03/08/19, revealed the facility was to issue the written notice far enough in advance the beneficiary could make a rational, informed decision or before the procedure is initiated. The facility failed to provide R5 written notification of the SNFABN prior to the end of the Medicare Part A stay.	F 582		
F 689 SS=D	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	F 689		

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F 689	Continued From page 3 §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 census totaled 92 residents, with three residents reviewed for falls. Based on observation, interview, and record review, the facility failed to effectively evaluate Resident (R) 45's causal factors for falls and enact appropriate interventions related to the identified causal factors. Findings included: - Review of R45's pertinent diagnoses from 01/12/21 "Physicians Orders Diagnosis" electronic medical records (EMR) revealed: atrial fibrillation (A-FIB, a rapid, irregular heartbeat), presence of a cardiac pacemaker (an implanted device to regulate the beating of the heart), hypertension (HTN, elevated blood pressure), Alzheimer's (a progressive mental deterioration characterized by confusion and memory failure), benign prostatic hyperplasia (BPH, a non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections). A review of the 10/01/20 "Admission Minimum Data Set" (MDS) revealed a brief interview for mental status (BIMS) of eight, indicating moderately impaired cognition. R45 had no rejections of care noted and required extensive two-person assistance for transfers, one-person assistance for walking in his room, and toileting. R45's unsteady gait required the use of a walker/wheelchair. No falls noted for the review period.	F 689		

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F 689	Continued From page 4	F 689		

Review of the 12/22/20 "Quarterly MDS" revealed a BIMS of six, indicating severely impaired cognition. R45 had no rejection of care noted and required extensive two-person assistance for transfers and toileting, supervision two-person assistance for walking in the room. R45's unsteady gait required the use of a walker/wheelchair. He experienced two or more non-injury falls and two or more injury falls since the last MDS.

Review of the 10/01/20 "Cognitive Care Area Assessment" (CAA) revealed R45's continued to show forgetfulness by trying to get up on his own and indicated a risk for falls.

Review of the 10/01/20 "ADL CAA" revealed the resident's unsteady gate made it challenging to perform transitions between bed, chair and scooter. During the assessment period, he received extensive assistance with walking and toileting.

Review of the 10/01/20 "Falls CAA" revealed, "see the Cognitive and ADL CAAs - same information applies."

Review of 12/15/20 "Morse Fall Assessment" revealed resident at high risk for falls. The facility did not provide a fall assessment before the 12/15/20 date as requested on 02/17/21.

Review of "Care Plan," revised 01/14/21, revealed R45 was alert and oriented to surroundings, forgetful, and might make poor/unsafe decisions.

Review of "ADL Care Plan," revised 01/14/21,

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F 689	Continued From page 5	F 689		

revealed he ambulated/transferred with a four-wheeled walker with standby assistance. For toilet use, R45 required contact guard assistance (1 staff minimum assistance). The resident slept in his recliner.

Review of "Bowel and Bladder Care Plan," revised 01/14/21, revealed he experienced occasional bladder incontinence and wore briefs. Staff encouraged and provided good peri-care.

Review of "Fall Prevention Care Plan," last revised 01/14/21, revealed staff was to complete visual checks while performing rounds, remind R45 to call for assistance, monitor for any gait or balance changes, assist with walking, transferring, and showering, provide reminder signs to encourage soft-touch call light usage, physical therapy consulted for strengthening, a lamp by the bedside, and a one-way glider which staff was to check stability and function daily.

Review of 09/25/20 to 09/27/20 "Voiding Diary" revealed resident averaged toilet use/incontinence every three to four hours while awake but lacked an assessment of the voiding diary. The facility failed to provide a more recent voiding diary as requested on 02/17/21.

Review of 10/02/20 at 08:35 AM "Progress Note" revealed R45 required one-person assistance with walker and gait belt. The resident stated, "I do not remember you telling me to call for help" after he went to the bathroom himself, and staff told him he needed to call for help.

Review of 10/05/20 at 09:10 AM "Progress Note" revealed he required one to two-person assistance with a gait belt for transfers/toileting,

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	175385	A. BUILDING _____ B. WING _____	C 02/16/2021

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F 689	Continued From page 6	F 689		

and he continued to be non-compliant with call light.

Review of "Fall Investigations" revealed R45 had a total of six falls from 12/04/20 to 01/08/21.

Review of "Fall Investigation" dated 12/04/20 at 07:15 PM revealed R45 had an unwitnessed fall in the bathroom after showering and toileting himself. Staff listed contributing factors as inadequate footwear and showering by himself. Facility staff identified the fall's casual factors as the amount of assistance R45 required and implemented the intervention of having R45 call for assistance when he felt weak and needed assistance.

Review of "Fall Investigation" dated 12/08/20 at 09:50 PM revealed R45 had an unwitnessed fall in his room while attempting to walk to the bathroom unassisted. Staff identified contributing factors as R45 having weakness while walking to the bathroom. Facility staff identified the causal factor as "got weak in the knees," and the interventions implemented were to have R45 call for assistance with walking, increase monitoring R45 for signs and symptoms of COVID-19 (viral disease), completion of a voiding diary, and ensuring one staff member assistance with walking.

Review of "Fall Investigation" dated 12/14/20 at 06:20 AM revealed R45 had an unwitnessed fall in the room after sliding out of the recliner. Staff listed contributing factors as COVID-19 and sliding out of the recliner. The staff did document that R45 had been incontinent of urine at the time of the fall. Facility staff identified the fall's causal factor as "slid out of the recliner" and

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	175385	A. BUILDING _____ B. WING _____	C 02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK	**200 SW 14TH NEWTON, KS 67114**

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F 689	Continued From page 7	F 689		

implemented using brightly colored reminders for R45 to utilize the new soft-touch call light.

Review of "Fall Investigation" dated 12/15/20 at 05:30 AM revealed R45 had an unwitnessed fall in his room when attempting to transfer and toilet himself. Staff listed contributing and causal factors as weakness from COVID-19 and needing to utilize the restroom. The facility then implemented leaving R45's door open at all times, changing to a manual recliner, keeping the call light within reach, and utilizing a hi/low bed.

Review of "Fall Investigation" dated 12/18/20 at 05:30 AM revealed R45 had an unwitnessed fall in his room while attempting to walk to the bathroom independently. Staff listed contributing factors as a recent COVID-19 infection which increased his weakness and confusion. Staff documented R45 had loose stool "spilling" from his brief upon staff's arrival. The facility staff listed the causal factor as "medical/mental/toileting status" and implemented scheduled toileting during the night, continued education about utilizing the call light, and signage to remind R45 to use the call light.

Review of "Fall Investigation" dated 01/08/21 at 06:15 PM revealed R45 had an unwitnessed fall in his room when he slipped out of his recliner. The "Fall Investigation" did not identify causal factors or interventions.

Observation of R45 on 02/11/21 at 07:53 AM revealed the resident in his room seated in his recliner with his eyes closed and call light in place. At 07:59 AM, Certified Nurse Aide (CNA) E entered the resident room with the resident's breakfast. At 08:24 AM, Licensed Nurse (LN) H in

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	175385	A. BUILDING _____ B. WING _____	C 02/16/2021

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ASBURY PARK	**200 SW 14TH NEWTON, KS 67114**

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F 689	Continued From page 8	F 689		

the resident room did not prompt/encourage the resident to the toilet. At 08:59 AM, CNA D walked by the resident room, and she asked him if he needed to use the restroom. The resident stated he could do it alone, and CNA D reminded the resident that he needed assistance and asked again if he needed to go now, and he responded no. The resident did no exhibit anger or other disruptive response to the CNA's question.

Observation of resident on 02/16/21 at 10:45 AM revealed the resident in his room with the room door closed. Upon entering the room after knocking, R45 was standing with his walker by the window with oxygen tubing located under his feet and the walker. R45 reported he "went to the bathroom and needed a new shirt, so he got one and put it on." CNA E then entered the room and assisted R45 back to the recliner.

Interview on 02/11/21 at 10:45 AM with CNA D revealed R45's fall risk is high, and he had a few falls in the facility. Some interventions included signs on the door to remind him to use his call light and walker, but he would not remember. She stated that he "usually called to go to the restroom," but staff checked on him and offered to the toilet often because he did experience incontinence.

Interview on 02/16/21 at 10:49 AM with CNA E revealed that she felt staff encouraging R45 with a toileting plan every two to four hours would be beneficial for this resident because he cannot remember to use his call light as directed.

Interview with LN F on 02/16/21 at 11:26 PM she stated that R45 had fallen "a lot" because he refused to use his call light. She indicated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175385	A. BUILDING _____ B. WING _____	C 02/16/2021

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ASBURY PARK	**200 SW 14TH NEWTON, KS 67114**

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F 689	Continued From page 9	F 689		

interventions for his falls included staff encouraging the use of the soft call light and reminders, frequent checks on the resident, and keeping his door open for safety. She then stated, "I think a toileting schedule would be beneficial, and after looking at his voiding diary, every two hours would be appropriate during the day." She then indicated that the fall risk meetings did not include the nursing staff, including CNAs, that worked with the resident. She then stated, "That would help find better interventions and root causes, and probably would have noticed the need for a toileting schedule/plan for him sooner if regular care staff were invited to give input."

Interview on 02/16/21 at 08:00 AM with Administrative Nurse B revealed she stated, "It seemed that while awake, R45 voided pretty regularly". She then indicated that a toileting plan would be beneficial based on looking at his BIMs, voiding diary, and his history of falls in the facility because of his confusion. She reported the voiding diary should have an assessment of the findings. The fall risk meeting staff had been so focused on COVID-19 they had overlooked a toileting plan as an intervention.

Review of the revised 2019 "Fall Management Program" policy revealed the policy's purpose was to provide an individualized assessment to minimize and prevent future falls and injuries from falls and identify causative information and trends useful in preventing future falls. The care plan would include individualized interventions designed to decrease the potential for falls. If the resident continues to fall, the staff will re-evaluate the situation and consider other possible reasons for the resident's falling and re-evaluate current interventions' continued relevance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175385	A. BUILDING _____ B. WING _____	C 02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK	**200 SW 14TH NEWTON, KS 67114**

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F 689	Continued From page 10 The facility failed to identify causal factors and implement interventions based on the causal factors to prevent R45 from falling.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility census totaled 92 residents with four reviewed for respiratory care. Based on observation, interview, and record review the facility failed to ensure that Resident (R)45 oxygen humidifier (device used to humidify supplemental oxygen) and oxygen tubing was maintained. Findings included: - Review of resident (R) 45 pertinent diagnoses from 01/12/21 "physicians orders diagnosis" electronic medical records (EMR) revealed: atrial fibrillation (A-FIB, a rapid, irregular heartbeat), presence of cardiac pacemaker (an implanted device to regulate the beating of the heart), Alzheimer's (a progressive mental deterioration characterized by confusion and memory failure). Review of the 10/01/20 "Admission Minimum	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 695	Continued From page 11	F 695		

Data Set" (MDS) revealed a brief interview for mental status (BIMS) of eight, indicating moderately impaired cognition. He required oxygen therapy.

Review of the 12/22/20 "Quarterly MDS" revealed a BIMS of six, indicating severely impaired cognition. He required oxygen therapy.

Review of "Care Plan," revised 01/14/21 revealed R45 required continuous oxygen per nasal cannula (NC). Staff were to monitor/assess for signs and symptoms of decreased oxygenation and checked oxygen (O2) saturations.

Review of "Physician Orders" dated 02/01/21 revealed R45 required O2 at 2 liters per minute via nasal canula continuously for shortness of breath.

Observation on 02/09/21 at 01:26 PM revealed R45s O2 tubing connected to the concentrator and the humidifier did not contain any liquid and cracks were noted in the plastic of the humidifier container.

Interview with Licensed Nurse (LN) F on 02/09/21 at 01:26 PM revealed the O2 tubing was replaced every two weeks, but she was unsure when the humidifier needed changed/filled.

Interview on 02/16/21 at 08:00 AM with Administrative Nurse B revealed every Saturday the nurses on first shift change out the O2 tubing and humidifier bottles.

Review of revised 02/16/21 "Infection Control Cleaning Respiratory Equipment" policy revealed the facility replaced cannula used by an individual

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F 695	Continued From page 12 resident within seven days and as needed (PRN) when obviously contaminated. Staff were to replace humidifiers according to manufacturer's instructions, usually every seven to ten days and follow the schedule and intervals specified in this procedure. The facility failed to ensure R45s humidifier and oxygen tubing was maintained for his use.	F 695		