STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175376	A. BUILDING _____ B. WING _____	C 12/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN HOME	**511 PARAMOUNT STREET SABETHA, KS 66534**

(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 investigation #KS00148744.	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 86 residents. The sample included three residents reviewed for falls. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 1 received adequate supervision and appropriate interventions to prevent a fall with injuries. On 5/23/19 at approximately 5:00 PM R1 exited the facility through an alarmed door in her wheelchair, attempted to stand and fell to the ground. As a result of the fall, she sustained a right eye laceration and orbital (eye socket) bruising, right and left arm bruising, abrasions, and three broken fingers on her left hand. Findings included: - R1's "Electronic Medical Record" (EMR) documented diagnoses that included Alzheimer's disease (a progressive mental deterioration that can occur in middle or old age, due to generalized degeneration of the brain).	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 "Annual Minimum Data Set" (MDS) dated 4/29/19 documented R1 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment. She required extensive assistance of one person for all "Activities of Daily Living" (ADLs) except eating. The "MDS" recorded R1 had one non injury fall since the last assessment.

The "Quarterly MDS" dated 10/14/19 documented the resident with a BIMS score of three, which indicated she had severely impaired cognition, and poor safety awareness. The resident used a wheelchair for mobility and occasionally a rolling walker with staff assistance. This MDS recorded the resident was at risk for falls but had none since the previous assessment.

The "Care Area Assessment" (CAA) for cognition dated 4/29/19 documented the resident continued with confusion much of the time, was able to make her needs known, and often needed redirection. She had no change in cognitive ability since last assessment, and the plan of care remained appropriate. The CAA for falls recorded the resident was at risk for falls and had at least one fall attempting to toilet self since the previous assessment. The CAA recorded she needed to rock her body and push off the arms of the chair when she attempted to stand. She had impaired balance during transfers and required staff assistance. The CAA documented the care plan would be developed to prevent falls with injury.

The care plan, last revised on 10/31/19, for "Fall Risk" recorded the resident primarily used her wheelchair for mobility. The care plan directed staff to provide self-directed activities, continue with therapy, ensure the call light was within

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reach and encourage use. The care plan directed staff to keep R1's bed in the lowest position, and ensure she was wearing appropriate footwear when ambulating. The care plan, last revised on 12/23/19, for "ADL's" documented R1 required assistance to complete her ADL's and directed staff to help her bear weight, and to transfer her with use of a front wheeled walker and gait belt. It further directed staff to provide a self-locking wheelchair. The care plan recorded R1 was unable to walk without help. The updated care plan for "Falls" dated 12/23/19 lacked documentation of any new interventions implemented after the fall, including the application of a watchmate (a signaling device alerting staff a confused resident is near a facility exit).

Review of the "Incident Report" in the "EMR" dated 12/20/19 at 4:43 PM recorded R1 was observed outside the physical therapy department door, on the ground, lying on her right side by her wheelchair with normal mentation (thought process). The report documented the possible cause as the resident fell out of her wheelchair and the resident hit her head. It documented that neurological checks were initiated and immediate first aid was given. A
skin check was performed and revealed the following injuries: a 1-centimeter (cm) laceration in the corner of her right eye, 10 cm x 7.5 cm x 5 cm bruising to her anterior left hand, and a 4 cm in diameter purple round bruise to the right forearm near the right wrist and a reddish-purple bruise to her right forearm. The physician and family were notified on 12/23/19 at 11:36 AM. The entry indicated Licensed Nurse (LN) R was interviewed and stated the alarm to the physical therapy door going outside was sounding, staff

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responded immediately, and the resident was found.

A radiology report for R1 dated 12/21/19 at 10:56 AM recorded acute nondisplaced fractures of the proximal phalanx (bone) of the 2nd, 3rd, and 4th fingers.

On 12/23/19 at 10:00 A.M. observation revealed two doors which had keyed locks that entered the Physical Therapy department off the 100 hall. Inside the physical therapy, another door was observed. That door was an alarmed fire door with a panic bar and 15 second delay. The door led outside of the facility.

On 12/23/19 at 2:37 PM R1 sat in her wheelchair at the nurse's station with notable bruising to her right eye, right and left arms. Her left hand and fingers were swollen.

Interviewed on 12/23/19 at 2:37 PM, R1 had noted confusion, word search difficulty, and reported she did not remember falling. R1 looked at the couch and stated, " I would like to lay down on it. I'm just always tired," and then said, "does the hand sometimes start to get better?"

The following witness statements were obtained on 12/23/19 at 2:00 PM:
A notarized "Witness Statement" from Administrative Staff F read: "I was notified by the [Administrative Staff C} at 4:45 PM per phone call that a watchmate bracelet was being placed on [R1's] left ankle due to her going out the physical therapy door. She had gotten into the physical therapy room by an inner door that was unlocked. I was not aware at that time that a fall or any injury had occurred. I then notified [Certified

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Physical Therapy Assistant (CPTA) N] at 5:20 PM that the therapy room door was found unlocked. On 12/21/19 I was notified at 7:50 AM per telephone from [LN J] as she wanted to clarify that an administrative nurse was notified of a fall with injury that occurred yesterday. I then spoke with Administrative Nurse E and she stated that she was aware of the fall with injuries. I arrived at the facility and assessed the resident and spoke with the family again and physician regarding her injuries. I took [R1] to [hospital] for x- rays and to have a cast placed on left hand due to three broken fingers on her left hand I then updated the family again, I also completed a new elopement assessment to reflect her need for a watchmate bracelet, checked all the physical therapy doors at that time to ensure they were locked."

A notarized "Witness Statement" from CPTA N read: "I left work (Physical Therapy Department) at 12:40 PM. Prior to leaving therapy department, I checked to ensure the whirlpool bath door was locked, the door that enters therapy department from nursing home was locked, the file cabinet was locked, and I exited through the door that leads to the North Village Apartments and I locked that door with a key. At 5:20 PM I received a text from [Administrative Nurse F] reporting that [R1] had gotten outside through the therapy department that, the door was not locked. I was informed that the resident was found by [Maintenance Staff X].

A notarized "Witness Statement" from LN H read: "In report, the night shift nurse reported that [R1] had fallen outside by the dumpster and that she had gotten out the exit door in the physical therapy room. She got into the physical therapy room by the door on the facilities side that was

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unlocked. The nurse also told me her injuries and to apply ice to her hand for twenty minutes three times a day."

Interviewed on 12/23/19 at 11:00 AM CPTA N stated she remembered locking all the doors before she left the facility on 12/20/19, but was told when R1 was found on the ground, the door was unlocked. She remembered locking the whirlpool room door and both doors to the therapy department when she left. CPTA N stated there is a duplicate key in a mail slot at the nurses station in case the nurses need to review a file.

Interviewed on 12/23/19 at 3:00 AM Administrator A Stated it is unknown how the physical therapy department door was unlocked. He stated the facility was conducting interviews regarding the situation.

On 1/2/2020 at 9:24 A.M. The facility emailed additional information, however a requested facility policy related to accident prevention was not received.

The facility failed to ensure this cognitively impaired independently mobile resident with a high fall risk received adequate supervision and appropriate interventions to prevent her from wandering to an outside locations, falling, and sustaining injuries related to that fall.