STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 a Health Resurvey. This 2567 was electronically sent to the facility on 8/27/19. A revision of this 2567 was electronically sent to the facility on 8/30/19.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §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. §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	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/30/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

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WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

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F 609	Continued From page 1	F 609		

incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

The facility reported a census of 55 residents with 14 sampled for review.. Based on observation, interview and record review the facility failed to report three incidents to the appropriate state agency which included unwitnessed falls with major injury for two cognitively impaired Residents (R) 31 and 100; and R30 for missing personal property.

Findings included:

- Review of Resident (R)100's undated "Physician Orders," documentation included diagnoses of vascular dementia with behavioral disturbance, multiple fractures (broken bones) of ribs on the left side, delusion (untrue persistent belief or perception held by a person although evidence shows it was untrue) disorder, spinal stenosis (narrowing or constricted of the spine), chronic pain, and repeated falls .

The admission "Minimum Data Set" (MDS), dated 02/15/19, documentation included the "Brief Interview for Mental Status" (BIMS) score of nine, indicating moderate cognitive impairment,with behaviors which included delusions, and rejection of care, one to three days of the look back period. The resident was independent with activities of daily living (ADLs) which included bed mobility, transfers, ambulation, toileting, and personal hygiene. Her balance during transition and walking was steady and she used a walker as an assistive device. She was continent of bowel and bladder. The resident reported frequent pain rated at five of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

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F 609	Continued From page 2	F 609		

ten, which interfered with her sleep. She received antipsychotic medication five days of the look back period, and antidepressant four days.

The quarterly MDS, dated 05/09/19, documentation included the following changes: BIMS score of five indicating sever cognitive impairment with hallucinations and delusions of one to three days during the look back period; required supervision with transfer, walk in corridor, locomotion on and off the unit, dressing, toilet use and personal hygiene; steady with balance during transition received insulin, antipsychotics, and antidepressants for seven days of the look back period; and had two or more non injury falls in the look back period.

The "Care Area Assessment" (CAA), dated 02/27/19, documentation for "Cognitive Loss/Dementia" included the resident admitted after hospitalization at a behavioral health unit from 01/30/19 to 02/11/2019. She had dementia as well as impaired kidney function. The resident was alert, self directed, with some baseline confusion that escalated when she gets upset. She was able to perform most activities of daily living (ADLs) with little staff supervision.

The CAA for "Activities of Daily Living" (ADLs) "Functional Rehabilitation Potential" documentation included the resident lived in assisted living prior to hospitalization and had a history of falls prior to hospitalization and one fall since admitted to the facility.

The CAA for "Falls" documentation included the resident diagnosed with dementia and delusions.

The "Care Plan" (CP), dated 2/27/19, advised

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

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F 609	Continued From page 3	F 609		

staff the resident was at risk for falls due to poor safety awareness, impaired cognition, impaired balance, and medications (psychotropic, diuretic, anti-hypertensive). The resident was aware of her toileting needs and was able to toilet herself without assistance from staff. The facility staff were to complete a fall assessment on admission, quarterly and with any change of condition and assess the environment for safety issues and intervene as needed. The staff should assist with appropriate footwear PRN (as needed) and assist with transfers, as needed. The nurses were advised to administer, monitor, and evaluate medications for increased risk for falls and offer the resident physical/occupational therapy for strengthening as appropriate. The care plan directed the staff to keep the bed in normal position.

Additional post fall interventions, dated 05/02/19, included adding a night light to the resident's room so she can see when getting up at night.

On 05/25/19, the care plan was revision post fall included offer non-skid socks at bedtime.

The "Electronic Medical Record" (EMR) "Progress Notes" (PN), dated 05/01/19 at 10:18 AM, documentation included R 100 found on the floor in her room at 10:00 PM. The resident stated she slipped to the floor and did not hit her head. The resident did not sustain any injury and the skin assessment did not reveal any new findings

The EMR "Event Report," dated 05/01/19, documentation included the resident experienced a unwitnessed non-injury fall in the room. The resident reported she had gotten out of bed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 609	Continued From page 4	F 609		

turn the TV off and when returning to bed in the dark she missed the edge of the bed. The immediate intervention added a night light to the resident's room so the resident could see when getting up at night. The care plan was revised to include the new intervention as noted above.

The EMR PN, dated 05/24/19 at 02:50 AM, documentation included the resident used her call light for assistance at 11:45 PM, the staff responded and found her sitting on the floor in front of the recliner. She stated she had been sitting in her recliner and decided to stand to look out of the window, turned, and slipped to the floor. The resident was not wearing her shoes, only socks. Immediate intervention initiated was for staff to offer the resident non skid socks at bedtime.

On 05/25/19 at 02:45 PM, the resident continued on fall follow-up with neuro checks within normal limits (WNL). She complained of pain of her ribs on the left side. No bruising noted. Nurse spoke with the physician who stated to watch the resident for now and call if any shortness of breath (SOB). The resident was up ambulating per usual with a rolling walker at will.

On 05/25/19 at 08:42 PM, the resident without complaints of pain or discomfort, ambulating with rolling walker.

On 05/27/19 at 06:03 PM, the resident complained of pain to her left ribs, rated the pain as seven of ten. The resident stated it hurt to breathe. Two staff required to assist the resident with transfer from bed to wheelchair. The physician was notified and the daughter transported the resident to the hospital for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

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F 609	Continued From page 5	F 609		

evaluation.

On 5/27/19 at 11:09 PM, the EMR "Event Report" documentation revealed the daughter reported the resident admitted to the hospital with three fractured ribs on the left side .

On 08/21/19 at 09:59 AM, Administrative Nurse E confirmed that a resident with a BIMS score of five indicated the resident with severe cognitive impairment. The resident had an unwitnessed fall on 5/24/19, resulting in a major injury (three broken ribs). Administrative Nurse E stated an unwitnessed fall by a severely cognitive impaired resident with 3 fractured ribs should have been reported to the appropriate state agency.

On 08/22/19 at 12:20 PM, Administrative Staff A, agreed a resident with a BIMS score of five indicated the resident with severe cognitive impairment. The resident had an unwitnessed fall on 5/24/19, resulting in a major injury (three broken ribs). Administrative Nurse E stated an unwitnessed fall by a severely cognitive impaired resident with 3 fractured ribs should have been reported to the appropriate state agency.

The undated facility policy for "Abuse, Neglect and Exploitation" defines neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy lacked address of a unwitnessed fall, reported by a cognitively impaired resident, resulting in major injury, as an allegation of neglect with actual harm that requires reporting to the appropriate state agency within 2 hours of being made aware of the major injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

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F 609	Continued From page 6	F 609		

The facility failed to report to the appropriate agency, an unwitnessed fall with major injury for the cognitively impaired resident with three broken ribs.

- Review of Resident (R)30's "Physician Orders" dated 06/19/19, documentation included diagnoses of hypoglycemia (low blood sugar), vascular dementia (progressive mental disorder characterized by failing memory, confusion due to low blood flow to the brain), with behavioral disturbances, delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue) disorders, hallucination (sensing things while awake that appear to be real, but the mind created), anxiety (mental or emotional reaction characterized by apprehension, uncertainty) disorder, and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The quarterly "Minimum Data Set" (MDS), dated 05/3/19, documentation included the resident with a "Brief Interview for Mental Status" (BIMS) score of eight, indicating moderate cognitive impairment.

The annual MDS, dated 07/18/19, documentation included the BIMS score of nine, indicating moderate cognitive impairment and R30 experienced delusions.

The "Care Area Assessment" (CAA), dated 07/23/19, for "Cognitive Loss/Dementia" documentation included the resident with a BIMS score of nine. She was delusional at times and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 609	Continued From page 7	F 609		

believed bugs were biting her or crawling out of her skin. When she misplaced items in her room, she would accuse staff or other residents of going through her room and stealing from her. She at times would start verbal arguments with other residents in the dining room. Her mood was labile (mood swings).

The "Care Plan" (CP), dated 08/20/19, and initiated on 12/11/17, advised staff of R30's impaired cognition due to vascular dementia and impaired communication. She had difficulty starting words or thoughts, but was able to communicate clearly if given adequate time to formulate conversation. Staff should give the resident simple choices and allow her to make her own decisions and encourage her to talk about things that were important to her.

On 5/22/19 at 11:34 AM, the "Electronic Medical Record" (EMR) "Progress Notes" (PM) documentation included the resident was upset this morning with vital signs obtained. She saw staff wearing pearl type necklaces for Roaring 20's Theme Day. She became verbally aggressive towards staff, believing they stole her pearl necklace. She grabbed one staff members pearls and proceeded to rub them on her teeth to determine if they were real because they looked exactly like her pearl necklace that was missing but her's were real and expensive. She did not get the results she was looking for and realized this staff member did not have her pearls so she moved on to say if that member did not have her pearls then someone in the laundry or another resident living next door to her stole them. The nurse assisted the resident in looking for her jewelry in her room but was unsuccessful in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 609	Continued From page 8	F 609		

locating the jewelry she was upset about. She again began ranting and raving and accusing several specific other people of stealing her jewelry. The resident then packed up all her jewelry that she was not wearing and put them in plastic baggies and placed them in a canvas tote to carry with her. She entered the dining room stating she did not know what to do. Everyone was going to be mad at her because they were all going to be questioned. Some of them were already getting mad. The nurse reassured the resident that not everyone would be questioned but if someone gets upset about being questioned that would be addressed when it occurred and not to worry about situations that had not occurred.

On 08/22/19 at 12:20 PM, Administrative Staff A confirmed the facility did not follow-up on this cognitively impaired resident's allegation of missing pearls, as required.

The undated facility policy for "Abuse, Neglect and Exploitation" defines exploitation as taking advantage of a resident for personal gain. The policy lacked address of a allegation of exploitation including a resident's missing personal property.

The facility failed to report to the appropriate state agency the resident's allegation of exploitation with her missing necklack made of real pearls.

- Resident (R) 31's, signed physician orders, dated 07/17/19, documented the resident admitted on 08/24/17, with the following diagnoses including; unspecified displaced fracture of upper end of left humorous (broken

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 609	Continued From page 9	F 609		

arm) and cerebrovascular accident (CVA) (stroke), sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).

Review of the "John Hopkins Fall Assessment," dated 02/05/19, found in R31's electronic medical record (EMR) under the "Observations" section indicated she had a score of 15. A score of 13 or more, represented she was at a high risk for falls.

The Care Plan, for falls, last reviewed on 08/06/19, evidenced she was at risk for falls, due to poor safety awareness/impaired cognition, and weakness. Her normal cognitive status was alert and confused and may not understand instruction or may forget quickly. Interventions directed the staff on 08/29/17, to " Please complete a Fall Assessment on admission, quarterly, and with any change in condition. Assess environment for safety issues and intervene as needed. Please assist her with appropriate footwear as needed (PRN). Assist her with transfers PRN. Administer, monitor, and evaluate medications for increased risk for falls. Offer physical/occupational therapy for strengthening as appropriate. The physician and family should be notified of any falls/incidents that occur within a reasonable time frame. On 08/29/17, orthostatic blood pressures monthly. On 06/07/19, the intervention was she preferred to have her door shut to maintain heat in her room. Make sure the door is closed after entering or leaving her room. The fall intervention initiated, on 11/26/18, directed staff the bed was put at a height that is comfortable and safe for her to transfer from without assistance, and the wall is marked to indicate appropriate bed height. On 03/11/19, an intervention for a fall, directed staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 609	Continued From page 10	F 609		

non-skid strips placed in front of her toilet to prevent her feet from sliding. On 07/11/19, a fall intervention for the fractured left humerus (arm) directed staff she had a pressure alarm on her bed, and to check for placement and function. On 07/23/19, a fall intervention included she was aware of her need to void/defecate but was now needing extensive staff assistance with toileting due to her left arm fracture. Please respond promptly to her call for assistance.

The fall, on 07/10/19 at 10:10 AM, per the "Progress Notes" (PN), found in the "Electronic Medical Record" (EMR), advised at 04:03 PM, R31 yelled for help and staff, upon entering her room, found her lying on the floor holding her left arm with her right hand. She reported she walked to the bathroom when her walker got "stuck on something" and rolled backwards. Staff assessment: the walker appeared to have struck the doorway to bathroom. She reported immediately complaints of a headache from hitting her head on the floor, back pain, and left shoulder/arm pain. She was given an option of going to the Emergency Room (ER)or waiting on X-ray here at facility and she reported she did not think she could wait that long because she could not move her left arm and there was a lot of pain.

The PN, dated 07/10/19 at 05:35 PM, advised she returned from ER visit at 04:04 PM, with left shoulder immobilizer in place, which was to stay in place until she was seen by an orthopedic doctor. The family member who accompanied her back from the ER reported R31 was given narcotic medication before leaving. Staff informed the family member R31 would be monitored closely and a bed alarm had been placed on her bed to alert the staff if she attempted to transfer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 609	Continued From page 11	F 609		

herself, along with a wheelchair for mobility.

The Event/Fall investigation, dated 7/10/19 at 1:00 PM, identified the root cause of the fall as the resident's walker bumped the doorway to the bathroom and rolled backwards. The staff initiated a bed exit alarm or a pressure alarm. Conclusions: She took herself to the bathroom independently during the day and night. She ran her walker into the door frame trying to get into the bathroom which knocked her off balance resulting in the fall. The lighting was dim at night impairing vision and she needed more assistance but would not call for assistance.

On 08/19/19 at 11:51 AM, observation revealed she rested quietly in bed with her eyes closed. The bed was in the low position, which lined up to the tape on the wall, and her call light was in reach.

Interview, on 08/21/19 at 11:03 AM, CNA OO stated R31 could transfer herself before the fall, and was not a big fall risk. She would ambulate with a front wheeled walker. She would use her call light if she required assistance. The resident now required a wheelchair, staff assistance for transfers, and had a bed alarm. She was a little confused. A message would go out over the Matrix (a CNA electronic documentation record) which alerted the staff of any interventions which were put on her care plan. The interventions were she was to wear a sling, but not anymore, the wheelchair was not to be too close to her, a bed alarm, and the bed height by the mark on the wall.

On 08/22/19 at 01:18 PM, Administrative Nurse E stated R31 was able to explain to us what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 609	Continued From page 12 happened, and she received education at a joint provider meeting, that if a resident could explain to you what happened, she did not have to call it in. The undated facility policy for "Abuse, Neglect and Exploitation" defines neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy lacked address of a unwitnessed fall, reported by a cognitively impaired resident, resulting in major injury, as an allegation of neglect with actual harm that requires reporting to the appropriate state agency within 2 hours of being made aware of the major injury. The facility failed to report to the appropriate state agency, an unwitnessed fall with major injury for the cognitively impaired resident with a fractured left humerus.	F 609		
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 §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 55 resident, with four residents sampled for accidents. Based on observation, interview, and record review, the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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		

facility failed to thoroughly investigate to determine contributing factors and causes of a fall and failed to implement an appropriate immediate intervention for one cognitively impaired Resident (R)30, to prevent further falls.

Findings included

- Review of Resident (R)30's "Physician Orders" dated 06/19/19, documentation included diagnoses of hypoglycemia (low blood sugar), pain, left foot pain, vascular dementia (progressive mental disorder characterized by failing memory, confusion due to low blood flow to the brain), with behavioral disturbances, delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue) disorders, hallucination (sensing things while awake that appear to be real, but the mind created), hypokalemia (low potassium in the blood), congestive heart failure (CHF- fluid build-up around the heart), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hypertension (high blood pressure), overactive bladder, type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anxiety (mental or emotional reaction characterized by apprehension, uncertainty) disorder, and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The Quarterly "Minimum Data Set" (MDS), dated 05/3/19, documentation included the resident with a "Brief Interview for Mental Status" (BIMS) score of eight, indicating moderate cognitive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 14	F 689		

impairment.

The Annual MDS, dated 07/18/19, documentation included the BIMS score of nine, indicating moderate cognitive impairment and experienced delusions. She was independent with bed mobility, transfers, walking, personal hygiene, and toileting. Her balance during transition and walking was steady. She had no functional limitation in range of motion (ROM) in upper or lower extremities and used a walker as an assistive device. The resident was occasionally incontinent of urine and always continent of bowel. She received scheduled pain medication and reported frequent pain, rated at six of ten, which did not interfere with day to day activities. The resident experienced one non- major injury fall. She received injections, insulin, antidepressants, and diuretic medications for seven days of the look back period. The resident did not receive therapy or restorative nursing program.

The "Care Area Assessment" (CAA), dated 07/23/19, for "Cognitive Loss/Dementia" documentation included the resident with a BIMS score of nine. She was delusional at times and believed bugs were biting her or crawling out of her skin. When she misplaced items in her room, she would accuse staff or other residents of going through her room and stealing from her. She at times would start verbal arguments with other residents in the dining room. Her mood was labile (mood swings). She received Venlafaxine and Trazadone to manage psychiatric symptoms. She does not wish to pursue psychiatric treatment outside of this facility. She does need assist with complex decisions and her daughter assists her with those decisions. She was independent with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 15	F 689		

her activities of daily living (ADLs).

The CAA, dated 07/23/19, for "Activities of Daily Living Functional Status/Rehabilitation Potential" documentation included the resident was independent with her ADL's. She does have a left side rail on the upper half of her bed that she uses as an enabler for self-positioning, but she sleeps in her chair most of the time. She walks independently throughout the community and outside with supervision during walking club. She takes herself to the bathroom. She wears pads and regular underwear and manages changing these on her own. She is continent of bowel and bladder.

The CAA, for "Urinary Incontinence/Indwelling Catheter", dated 07/23/19, documentation included the resident was continent of bowel and bladder. She does have occasional dribbling with urge incontinence when coughing or laughing. She takes Lasix daily and has diagnosis of overactive bladder for which she received oxybutynin.

The CAA, for "Falls", dated 07/23/19, documentation included the resident with insulin dependent diabetes which she has episodes of hypoglycemia (low blood sugar) at times due to amount of insulin given and failure to eat much of the following meal. She gets very weak and stuporous when blood sugar is low increasing her risk of falls. She had a fall with abrasions on 01/21/19 and 05/21/19. Her fall risk score of 15 indicated the resident at high risk for falls

The "Care Plan" (CP), dated 08/20/19, and initiated on 12/11/17, advised staff the resident was at risk for falls due to medications,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 16	F 689		

incontinence, vision changes and visual hallucinations. She needed assistance with ADL due to impaired cognition, diabetes, and heart disease. She used a side rail on the bed to assist with mobility and repositioning. She required zero to one staff assistance with toileting, due to her urinary incontinence and prefers to wear briefs. The staff should place the bed in normal position, assess the environment for safety issues, and intervene as needed. The staff were to assist the resident with appropriate footwear, and transfers as needed.

A "Care Plan Evaluation Note," dated 05/21/2019, documentation included the resident with dried blood on her night gown. On assessment, she had a nickel size abrasion on her left knee with dried blood present surrounding the distal border. When asked what happened, the resident reported that she fell around 04:00-04:30 AM. The resident stated she had not reported the fall at the time it happened, and that she did not hit her head. She verbalized that she had to go to the bathroom and got up out of her chair, took her cane, and walked toward the bathroom but she had gotten dizzy and fell to her left knee on the carpeting.

Additional care plan approach, dated 05/22/2019, documentation included "Reviewed care plan interventions, no new interventions needed at this time. . . independent with transfers, ambulation and toileting. She is encouraged to transition from laying to sitting/sitting to standing slowly, use SR (side rail) on bed for stability."

The "John Hopkins Fall Risk Assessment" score ratings were as follows: scoring of zero to five points equal a low fall risk; six to 13 points equal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 17	F 689		

a moderate fall risk; and greater than 13 points equals a high fall risk.

R 30's "John Hopkins Fall Risk Assessment", dated 05/02/19, documented the fall risk score as eight, indicating moderate fall risk.

R 30's "John Hopkins Fall Risk Assessment", dated 07/16/19, documented the fall risk score as 15, indicating high fall risk.

The "Electronic Medical Record" (EMR) "Progress Notes" (PN), dated 05/21/19 at 10:31 AM, documentation included" . . . 06:30 AM, noted the resident with dried blood on her night gown. On assessment noted left knee with nickel size abrasion with dried blood present surrounding distal border. When asked what happened, she reported that she fell around 04:00-04:30 AM. She stated she had not reported it at the time it happened and that she did not hit her head. She verbalized that she had to go to the bathroom and got up out of her chair, took her cane, and walked toward the bathroom but she had gotten dizzy and fell to her left knee on the carpeting. Abrasion cleaned with wound cleanser and covered with a band-aid. Blood sugar checked and results of 291. Blood Pressure (BP) sitting 157/67, and BP standing 144/66. R 30 stated she did not remember feeling dizzy when she stood up but she did get dizzy when she started walking. Educated R30 to try making position changes slowly and wait a brief moment before making next move. Showed her how to go from sitting to standing with her walker and then pause until she didn't feel dizzy before taking steps to walk. She returned demonstration however she was only consistent with this when she thinks someone is observing otherwise she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 18	F 689		

has continued to just stand and go with no altered gait pattern or wavering due to dizziness noted."

The EMR "Event Report," dated 05/23/19, documentation included the resident fell in her room, experienced mild pain, and sustained an abrasion. The resident received range of motion (ROM) of all extremities without pain. She reported she experienced dizziness when she took herself to the bathroom and fell to her left knee and sustained an abrasion. Review of the care plan interventions indicated no new intervention needed at this time. The resident was currently independent with transfers and ambulation.

On 08/21/19 at 11:46 AM, the resident ambulated independently with a rolling walker, to the nurses' station.

On 08/21/19 at 02:39 PM, the resident independently stood from a sitting position using the walker for support.

On 08/21/19 at 01:03 PM, Certified Nurse Aide (CNA) M reported the care plan advised staff of the resident's individual needs and preferences. She stated when a resident falls the nurse should assess the resident, direct the staff, and initiate a huddle to discuss the cause of the fall. The nurse should put an immediate intervention in place to prevent further falls. CNA M stated the resident had behaviors, which included hallucinations. She reported the resident as independent with walking with the use of a walker and staff try to make her aware to use the call light if having any problems so staff can assist her. CNA M reported the resident sleeps in her recliner and the staff keep the walk way clear in the resident's room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 19	F 689		

On 08/21/19 at 05:49 PM, CNA O reported the care plan provided instructions to the staff regarding individual needs and preferences of the resident. She stated when a fall occurred, the nurse assessed the resident to determine the cause of the fall, tells staff what to do to care for the resident, and then the staff discuss the fall and a new intervention should be put in place to prevent further falls.

On 08/21/19 at 02:55 PM, Licensed Nurse (LN) G, stated the resident's care plan provided direction to the staff related to their individual needs and preferences. She explained the nurses should revise the care plan with any change of condition or following a fall to prevent further falls. The investigation should be initiated by the charge nurse to include the review of the resident's care plan to ensure care planned interventions were in place, initiate an investigation to determine the cause of the fall and revise the care plan with an immediate intervention to prevent further falls. Furthermore, LN G stated a cognitively impaired resident would not necessarily remember to use a call light or to ask for assistance from the staff. She confirmed the care plan lacked a new immediate intervention following the 05/21/19, resident fall.

On 08/21/19 at 05:12 PM, LN H reported the care plan should have interventions in place to advise staff of ways to prevent falls. The staff reviewed the interventions were reviewed and updated them routinely by the interdisciplinary team (IDT). However the charge nurse initiated the investigation to determine the cause of the fall and implemented an immediate intervention to prevent further falls. LN H stated she would use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 20	F 689		

nursing judgement, to determine a resident's mental status as part of the investigation process. She verified the fall investigation components included the BIMS score and the staff providing a cognitively impaired resident with education or advising them to call for assistance was not an appropriate intervention to prevent further falls.

On 08/21/19 at 09:59 AM, Administrative Nurse E confirmed a resident with a BIMS score of eight on the MDS prior to the resident fall and nine on the most recent MDS, both indicating moderate cognitive impairment. The resident's event notes and PN documented an unwitnessed fall on 05/21/19. The notes included "no new intervention needed at this time, education of the resident to change position slowly." Administrative Nurse E verified the staff should initiate an investigation to determine the cause and/or contributing factors when a resident falls. The charge nurse should implement an immediate intervention falling a fall to prevent further falls. Administrative Nurse E stated the facility failed to thoroughly investigate the residents fall and/or to implement an appropriate immediate intervention, as expected.

On 08/22/19 at 12:20 PM, Administrative Staff A, agreed education was not an appropriate intervention for a cognitively impaired resident with a BIMS score of eight or nine. The facility failed to complete a through investigation to determine the cause and/or contributing factors of the resident's fall and failed to implement an appropriate immediate intervention to prevent further falls.

The facility policy, dated 07/2017, for "Accidents and Incidents-Investigating and Reporting"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 21 documentation included the Nurse Supervisor/Charge Nurse and/or department director or supervisor shall promptly initiate and document investigation of the accident or incident. ". . . Any corrective action taken. . . Incident /Accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities." The facility failed to investigate to identify the causative and contributing factors for this cognitively impaired resident 's fall. The facility failed to implement an immediate intervention to prevent further falls for the resident.	F 689		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility reported a census of 55 residents. Based on observation, interview, and record review, the facility failed to conduct annual performance reviews, for two of the five direct care staff reviewed, to ensure the residents receive adequate cares. Findings included: - During review of five direct care staff's employment records, the facility did not complete	F 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 730	Continued From page 22 two of the five, annual performance reviews. Per review of employee records, Certified Nurse Aide (CNA) MM hired on 02/09/18 and lacked a yearly evaluation. CNA NN, hired on 03/13/14 and lacked a yearly evaluation. On 08/22/19 at 2:00 PM, Administrative Staff A explained the facility did not complete yearly evaluations. "We have the employee complete a self evaluation, if they want a raise, they will complete the self evaluation." Administrative Staff A also confirmed that the employee records of the two identified CNAs, did not have the required yearly evaluations completed. The facility failed to conduct annual performance reviews for the two direct care staff, to ensure the residents received adequate cares.	F 730		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 755	Continued From page 23	F 755		

must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 55 residents, with 14 residents selected for review. Based on observation, interview, and record review, the facility failed to assure the accurate acquiring, and administering of a respiratory medication for one sampled Resident (R) 45.

Findings included:

- Resident (R) 45's, signed Physician Orders, dated 07/31/19, documented the resident admitted on 02/08/19, with the following diagnosis of Chronic obstructive pulmonary ([COPD] a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The admission "Minimum Data Set" (MDS) dated 02/14/19, revealed the resident had a "Brief Interview for Mental Score" (BIMS) score of 14, indicating intact cognition. The resident independent with all activities of daily living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 755	Continued From page 24	F 755		

(ADL's), and without shortness of breath.

The "Care Area Assessment" (CAA) dated 02/21/19 for ADL's advised she was independent with all ADL's except bathing. She ambulated with a walker independently and she used a wheelchair for long distances that she could self propel.

The quarterly MDS, dated 08/08/19, revealed the resident had a BIMS score of 12, indicating moderately impaired cognition. The resident required supervision for ADL's. The resident had shortness of breath with exertion and when lying flat.

The Care Plan, reviewed on 08/13/19, located in the "Electronic Medical Records" (EMR) advised the resident used oxygen, 2L (liters) per nasal canulla (NC) at night for COPD with nocturnal desaturation. Intervention, dated 08/19/19 instructed the staff to report any changes to the physician, to reorder yupelri and perforomist nebulizer inhalation medications from the supplier when R45 was down to a 7 day supply.

R45's "Physician Orders" included yupelri, (revefenacin) a solution for nebulization; 175 mcg (micrograms)/3 mL (milliliters), administer 1 vial, per inhalation daily for COPD, started on 06/28/19.

R45's "Physician Orders" included perforomist (formoterol fumarate), solution for nebulization; 20 mcg/2 mL, 1 vial, per inhalation twice a day (BID) for COPD, started on 06/28/19.

The "Progress Note" (PN) dated 08/10/19 at 10:14 AM, located in the EMR, advised a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 755	Continued From page 25	F 755		

medication request faxed to the facility pharmacy for a refill on perforomist and yulperi.

A PN dated 08/19/19 at 03:10 PM, advised this was a late entry note for 8/15/19, this nurse received a call from the facility's pharmacy at 03:57 PM, and was informed the pharmacy did not supply the medication. Certified Medication Aide (CMA) S reported R45 only had 1 vial of the yupelri and 3 days of the perforomist. Staff then contacted the oxygen company who supplied the medication at 03:46 PM, and informed the company R45 only had 1 vial of yupelri left, and was informed the medications would be sent out that evening.

A PN datd 08/19/19 at 7:30 PM, advised as of this time, R45's respiratory medications yupelri and performist had not been delivered to the facility. Staff called the oxygen company and was transferred to a voicemail stating that the office was closed. Staff to pass onto oncoming shift to contact the oxygen company in the morning.

The PN dated 08/20/19 at 9:37 AM, advised the oxygen company notified and reported the yupelri was sent out on 08/16/19 and should arrive by 08/22/19 and the performomist was sent out on 08/19/19, and should arrive by 08/23/19. Notified R45's physicians, and left message to call the facility.

R45's physician ordered on 08/20/19, ipratropium-albuterol solution for nebulization, 0.5 mg-3 mg,(2.5 mg base/3 mL), 1 vial every 4 hours a needed for shortness of breath.

The 08/19 "Electronic Medication Administration Record" (E-MAR) advised perforomist medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

(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 755	Continued From page 26	F 755		

not administered on 08/19/19, 08/20/19, 08/21/19, and 08/22/19 at 7:00 AM-11:00 AM, due to the medication not available. The medication not administered on 08/19/19, 08/20/19, and 08/21/19 at 07:00 PM-11:00 PM. The medication was to arrive on 08/23/19, and this would mean the resident would not receive 7-8 doses of the medication. The facility staff did not notify the physician, of the lacking medication, until 08/20/19.

The 08/19, E-MAR identified the yupelri not administered on 08/17/19, 08/18/19, and 08/19/19, and 08/20/19. The resident did not receive the medication for four days.

Furthermore, the physician was not notified until 08/20/19, of both medication not being available to administer to the resident.

On 08/20/19 at 10:54 AM, observation revealed she did not have any signs and symptoms of difficulty breathing.

On 08/20/19 at 05:00 PM, sat at the dining room table, and reported she did not have any difficulty breathing at this time.

On 08/21/19 at 10:30 AM, she sat in her room and received her yupelri as ordered.

On 08/19/19 at 01:13 PM, R45 stated she was out of her breathing medication treatments since Saturday.

On 08/19/19 at 02:56 PM, Certified Medication Aide (CMA) S stated the medication was refilled on Thursday when she reordered both medications. Staff S stated the perforomist was

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	175250	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

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F 755	Continued From page 27	F 755		

given last on 08/18/19 at 7:00 PM, the yupelri was given last on 08/16/19.

On 08/20/19 at 05:00 PM, R45 stated a nurse went to pick up the yupelri medication from the doctors office, however the doctor was out of the perforomist medication. She thought there must have been a mix-up at the oxygen company and when the medication was called in they did not order it.

On 08/19/19 at 02:56 PM, Licensed Nurse (LN) G stated the family had to clear up whatever the problem was. The staff tried to get the medication through the facility pharmacy but it would have cost the resident $600.00 a month. It could be ordered through the oxygen company under Medicare Part B.

On 08/20/19 at 4:45 PM, LN I stated one of the nurses went to the pulmonoligist to pick up samples of the yupelri medication, however the doctor was out of her perforomist medication, and it would not be to the facility until Friday. LN I stated she was not sure when they notified the physician since this issue has been ongoing.

On 8/21/19 at 4:17 PM, LN G stated the oxygen company called two times a week to ask for any medication refills. CMA S placed a call the regular pharmacy and the resident's insurance did not cover the breathing treatments, so that was why the staff ordered the medication through the oxygen company who kept telling the staff the medication was on it's way. Now R45 would receive a 10 day supply at a time.

On 08/22/19 02:06 PM, Administrative Nurse E stated the staff called the pharmacy on the tenth

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F 755	Continued From page 28 regarding a refill. Staff E stated she was not sure why the staff did not call the doctor over the weekend and let the doctor know R45 was out of the medication, and obtain an alternative medication until both the yupelri and the perforomist would arrive. The facility policy for pharmacy, dated 04/23/12, advised the pharmacy was to provide medications packaged in accordance with the facility's needs, and providing routine and timely pharmacy services six days per week and emergency service 24 hours per day seven days a week. The facility failed to assure accurate acquiring and administering of these two respiratory inhalation medications for the resident who went without ordered inhalation treatments for 4-8 days.	F 755		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		

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F 880	Continued From page 29	F 880		

reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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F 880	Continued From page 30	F 880		

corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 55 residents. Based on observation and interview the facility failed to maintain an effective infection control program related to a sanitary environment to help prevent cross contamination and the spread of infections in the laundry, to ensure appropriate handling, storage, processing, and transportation of linens, for the resident's of the facility.

Findings Included:

- The laundry tour, on 08/22/19 at 10:32 AM, with Housekeeping Supervisor U and Maintenance Director V revealed infection control concerns which included:

The washing machine door with lime build-up running below the glass front to the base, which was unsanitizable.

The dryer front with exposed bare metal, which was unsanitizable.

The vinyl cover for the linen cart, used for transporting clean linen and resident clothing, was thread bare, ripped, and unsanitizable.

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F 880	Continued From page 31 On 08/22/19 at 10:32 AM, Housekeeping Supervisor U and Maintenance Director V, verified the above findings and agreed the surfaces were not sanitizable. The facility lacked a policy related to sanitizing surfaces in the laundry. The facility failed to maintain an effective infection control program related to the handling, storage, processing, and the transporting linens to prevent the cross contamination and the spread of infection, for the residents of the facility.	F 880		