| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| PARK LANE NURSING HOME | 210 E PARK LANE SCOTT CITY, KS 67871 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of complaint investigation #104263 and #100574. | F 000 | | |
| F 221 SS=D | 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS<br><br>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 63 residents. The sample included 3 residents, with 1 resident reviewed for physical restraints. Based on observation, interview, and record review the facility failed to ensure 1 of 1 sampled resident was free of physical restraint use. (#1)<br><br>Findings included:<br><br>- Resident #1's (POS) physician order sheet, dated 8/15/16, revealed diagnoses that included: dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), insomnia (inability to sleep), essential hypertension (high blood pressure), avulsion fracture of the left talus (a small piece of bone chipped off the ankle), left hip fracture (broken bone in the left hip), osteoarthritis (degenerative changes to one or many joints characterized by | F 221 | | |

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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swelling and pain), and arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement).

The quarterly (MDS) Minimum Data Set assessment, dated 7/19/16, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 12, indicating moderate cognitive impairment, and required extensive assistance of 1 staff for bed mobility, limited assistance of 1 staff for transfers and participated in a toileting program.

The (ADLs) Activities of Daily Living (CAA) Care Area Assessment, dated 2/5/16, revealed the resident needed assistance of 1 staff, with a gait belt and walker for ambulation in his/her room, and toileting. The resident attempted to walk to the toilet on his/her own and had a fall. The CAA revealed physical and occupational therapy continued to work with the resident.

The 8/2/16 care plan indicated the resident made poor decisions, and directed staff to ask the resident if he/she needed anything before leaving him/her in the recliner or bed, encourage the resident to lock the wheelchair, then push up from the chair to stand, and to reach back when sitting down. The care plan further directed staff to place the call light within the resident's reach, place gripper socks on the resident, walk the resident to every meal 1 way, with a gait belt, walker, and assistance of 1 staff. As part of a restorative program, staff walked the resident to and from his/her room to the administrative office door, with a gait belt and assistance of 1 staff, 3 days a week. The care plan directed staff to assist the resident to the bathroom every 2 to 2.5 hours, do not leave the resident in the room in

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his/her wheelchair unattended, unplug the lift recliner when the resident sat in the chair, and complete hourly checks.

The Morse Fall Scale Assessments dated 8/15/16, 7/16/16, 4/26/16, 3/23/16 revealed the resident was at high risk for falls.

Review of the medical record revealed no assessment of the resident's ability to use the remote control for the recliner.

Review of the medical record revealed no assessment for resident restraints.

On 2/12/16, the fall investigation stated staff found the resident seated on the floor with the power recliner raised to the recliner's highest position. Staff documented the resident's impaired cognition did not allow him/her to use the remote control for the recliner correctly. Staff changed the care plan and directed the staff to unplug the recliner when the resident sits in the chair.

On 4/21/16, the fall investigation stated staff found the resident in his/her room in the recliner, with gripper socks on, yelling for "mama". The staff observed the resident stand and walk toward the doorway, wearing gripper socks. Staff noted the recliner in the raised position, with the remote controller in the side pouch of the recliner, as the aide reached the resident the resident lost his/her balance and staff assisted him/her to the floor. The wheelchair was next to the recliner, the walker was out of reach, and the call light within reach from a seated position in the recliner. The nurse assessed the resident and educated staff to unplug the recliner when not raising or lowering

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the chair as staff added to the care plan after the 2/12/16 fall from the recliner. Staff assisted the resident to the bathroom, then unplugged the recliner.

On 8/10/16 at 12:43 PM, the fall investigation stated an aide heard a trash can hit the wall in the resident's room. The aide went to the room and found the resident on the floor lying on his/her back. Staff had observed the resident sitting in the recliner prior to the fall and the resident got out of the recliner on his/her own. The resident yelled in pain, when the nurse attempted to move his/her left leg, and he/she obtained a physician order to send the resident to the emergency room by ambulance for further evaluation. The investigation note indicated the root cause analysis revealed the resident fell because he/she was confused and upset with staff and unaware of his/her location and the reason. The investigative note did not include a statement indicating the recliner footrest was elevated.

The 8/10/16, hospital Emergency Physician Record - Fall form indicated the resident reported the recliner footrest was elevated, he/she attempted to exit the recliner without lowering the footrest, and used the table for leverage. The resident stated the table moved and he/she fell. The record indicated the resident had mild pain in the pelvis, left hip, and lower back.

The 8/10/16, radiology report, stated the resident had a left femoral neck fracture (a crack near the hip joint, located near the top of the bone of the leg) and fractures of the right superior (a part of the hip/pubic bone, that is triangular is shape), inferior pubic ramus (the part of the pelvic bone that is thin and flat), and the right sacrum (a

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| F 221 | Continued From page 4 | F 221 | | |

triangular bone that forms the back section of the pelvis).

On 8/29/16 at 5:20 PM, Nurse Aide D stated the resident was confused and required 1 staff assist for transfers prior to breaking his/her hip. Nurse Aide D verified staff raised the footrest on the recliner when the resident sat in the chair, then unplugged the power cord as directed by the care plan.

On 8/30/16 at 4:46 PM, Nurse E stated to Administrative Nurse A, at the time of the resident's fall, the footrest of the recliner was elevated and the resident fell from that position out of the chair. Nurse E verified, unplugging the power cord on the recliner with the footrest elevated restrained the resident.

On 8/30/16 at 4:50 PM, Administrative Nurse A verified the care plan intervention included unplugging the power recliner so the resident could not raise or lower the chair on his/her own. Administrative Nurse A further verified staff kept the recliner's remote control out of the resident's reach, and stated a restraint assessment was not done on the recliner with the footrest elevated.

On 9/7/16 at 4:29 PM, Administrative Nurse A verified staff used the alarm on the bed only and further stated when the resident fell out of the recliner, the footrest of the recliner was elevated, no alarm in place, and the staff checked the resident 5 or 10 minutes before the fall.

The facility's December 2007 Safety and Supervision of Residents policy and procedure directed the interdisciplinary care team to analyze information obtained from assessments and

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| F 221 | Continued From page 5<br>observations to identify specific accident hazards or risks for that resident. The care team shall target interventions to reduce accident risks and hazards and should include the following:<br>Communicating specific interventions to all relevant staff<br>Assigning responsibility for carrying out interventions<br>Providing training as necessary<br>Ensuring implementation of the interventions<br>Documenting interventions<br><br>The facility failed to ensure Resident #1 was free from physical restraints by evaluating the resident's ability to correctly use the recliner remote control correctly and use of the recliner footrest in the elevated position. | F 221 | | |
| F 323 SS=G | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 63 residents. The sample included 3 residents. Based on observation, interview and record review the facility failed to develop and implement timely and effective interventions to prevent future falls for 1 of 3 sampled residents reviewed for accidents. | F 323 | | |

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Resident #1 experienced falls, including falls from the recliner, with one resulting in four fractures.

Findings Included:

- Resident #1's (POS) physician order sheet, dated 8/15/16, revealed diagnoses that included: dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), insomnia (inability to sleep), essential hypertension (high blood pressure), avulsion fracture of the left talus (a small piece of bone chipped off the ankle), left hip fracture (broken bone in the left hip), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement).

The quarterly (MDS) Minimum Data Set assessment, dated 7/19/16, indicated the resident had a (BIMS) Brief Interview for Mental Status , score of 12 indicating moderate cognitive impairment, and required extensive assistance of 1 staff for bed mobility, limited assistance of 1 staff for transfers, and participated in a toileting program.

The (ADLs) Activities of Daily Living (CAA) Care Area Assessment, dated 2/5/16, revealed the resident needed assistance of 1 staff, with a gait belt and walker for ambulation in his/her room, and toileting. The resident attempted to walk to

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| F 323 | Continued From page 7 | F 323 | | |

the toilet on his/her own and had a fall. The CAA revealed physical and occupational therapy continued to work with the resident.

The 8/2/16 care plan indicated the resident made poor decisions, and directed staff to ask the resident if he/she needed anything before leaving him/her in the recliner or bed, encourage the resident to lock the wheelchair, then push up from the chair to stand, and to reach back when sitting down. The care plan further directed staff to place the call light within the resident's reach, place gripper socks on the resident, walk the resident to every meal 1 way, with a gait belt, walker, and assistance of 1 staff, and as part of a restorative program. Staff walked the resident to and from his/her room to the administrative office door, with a gait belt and assistance of 1 staff, 3 days a week. The care plan directed staff to assist the resident to the bathroom every 2 to 2.5 hours, do not leave the resident in the room in his/her wheelchair unattended, unplug the lift recliner when the resident sat in the chair, and complete hourly checks.

The Morse Fall Scale assessments dated 8/15/16, 7/16/16, 4/26/16, 3/23/16 revealed the resident was at high risk for falls.

Review of the medical record revealed no assessment of the resident's ability to use the remote control for the recliner.

On 2/12/16, the fall investigation stated staff found the resident seated on the floor with the power recliner raised to the recliner's highest position. Staff documented the resident's impaired cognition did not allow him/her to use the remote control for the recliner correctly. Staff

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changed the care plan and directed the staff to unplug the recliner when the resident sits in the chair.

On 3/20/16, the fall investigation stated staff attempted to direct the resident to turn his/her body. The resident did not listen, sat down too early, and the aide assisted him/her to the ground. The intervention added to the care plan directed staff to provide clear, simple directions, one at a time.

On 3/23/16, the fall investigation stated staff found the resident sitting on the foot pedals of the wheelchair in his/her room. Two staff assisted the resident to the bathroom and then back to bed. The resident stated staff returned him/her to the room after bingo and left him/her in the wheelchair. An intervention added to the care plan directed staff to not leave the resident unattended in the wheelchair in his/her room.

On 4/21/16, the fall investigation stated staff found the resident in his/her room in the recliner, with gripper socks on, yelling for "mama" . The staff observed the resident stand and walk toward the doorway, wearing gripper socks. Staff noted the recliner in the raised position, with the remote controller in the side pouch of the recliner, as the aide reached the resident and assisted him/her to the floor. The wheelchair was next to the recliner, the walker was out of reach, and the call light within reach from a seated position in the recliner. The nurse assessed the resident and educated staff to unplug the recliner when not raising or lowering the chair as staff added to the care plan after the 2/12/16 fall from the recliner. Staff assisted the resident to the bathroom, then unplugged the recliner.

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Review of the 8/10/16, hourly safety check sheet revealed staff observed the resident on the 10 to 6 shift and documented completion of the task by checking 4 boxes, all timed at 2:30 AM, 2 boxes at 2:31 AM, and every hour between 6:13 AM and 12:00 PM.

On 8/10/16 at 12:43 PM, the fall investigation stated an aide heard a trash can hit the wall in the resident's room. The aide went to the room and found the resident on the floor lying on his/her back. Staff had observed the resident sitting in the recliner prior to the fall. The resident got out of the recliner on his/her own. The resident yelled in pain, when the nurse attempted to move his/her left leg. The nurse obtained a physician order to send the resident to the emergency room by ambulance for further evaluation. The investigation note indicated the root cause analysis revealed the resident fell because he/she was confused and upset with staff and unaware of his/her location and the reason. The investigative note did not include a statement indicating the recliner footrest was elevated.

The 8/10/16, hospital Emergency Physician Record - Fall form indicated the resident reported the recliner footrest was elevated, he/she attempted to exit the recliner without lowering the footrest, and used the table for leverage. The resident stated the table moved and he/she fell. The record indicated the resident had mild pain in the pelvis, left hip, and lower back.

The 8/10/16, radiology report, stated the resident had a left femoral neck fracture (a crack near the hip joint, located near the top of the bone of the leg) and fractures of the right superior (a part of

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the hip/pubic bone, that is triangular is shape), inferior pubic ramus (the part of the pelvic bone that is thin and flat), and the right sacrum (a triangular bone that forms the back section of the pelvis).

On 8/29/16 at 5:20 PM, Nurse Aide D stated the resident was confused and required 1 assist for transfers prior to breaking his/her hip. Nurse Aide D stated the resident used the recliner control once and raised the recliner to the highest point and slid out of the chair. The nurses made the decision to remove the recliner control from the resident's access.

On 8/30/16 at 3:50 PM, Nurse E stated the resident was very confused, tried to get up from the recliner on his/her own, and used the call light part of the time.

On 8/30/16 at 4:46 PM, Nurse E stated to Administrative Nurse A, at the time of the resident's fall, the footrest of the recliner was elevated and the resident fell from that position out of the chair.

On 8/30/16 at 4:50 PM, Administrative Nurse A verified the care plan intervention included unplugging the power recliner so the resident could not raise or lower the chair on his/her own. Administrative Nurse A further verified staff kept the recliner's remote control out of the resident's reach, to prevent him/her from getting up on his/her own without staff assistance. administrative Nurse A stated a restraint assessment was not done on the resident seated in the recliner with the footrest elevated.

On 9/7/16 at 4:29 PM, Administrative Nurse A

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| F 323 | Continued From page 11<br>verified staff used the alarm on the bed only and further stated when the resident fell out of the recliner, the footrest of the recliner was elevated, no alarm in place, and the staff checked the resident 5 or 10 minutes before the fall.<br><br>The facility's December 2007 Safety and Supervision of Residents policy and procedure directed the interdisciplinary care team to analyze information obtained from assessments and observations to identify specific accident hazards or risks for that resident. The care team shall target interventions to reduce accident risks and hazards and should include the following:<br>Communicating specific interventions to all relevant staff<br>Assigning responsibility for carrying out interventions<br>Providing training as necessary<br>Ensuring implementation of the interventions<br>Documenting interventions<br><br>The facility failed to initiate timely and effective interventions to prevent future falls for this cognitively impaired resident, who fell from a recliner 2 times and sustained multiple fractures. | F 323 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it - | F 441 | | |

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(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) 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.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

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

This REQUIREMENT is not met as evidenced by:
The facility had a census of 63 residents. The sample included 3 residents. Based on observation, record review, and interview the facility staff failed to wash hands upon entering a resident room, prior to performing direct care, and change soiled gloves during personal hygiene care for 2 of 3 sampled residents. (#2, #3)

Findings included:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175525 | A. BUILDING _____ B. WING _____ | C 09/08/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PARK LANE NURSING HOME | 210 E PARK LANE SCOTT CITY, KS 67871 |

| (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 |
|---|---|---|---|---|
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- On 8/29/16 at 5:20 PM, observation revealed Nurse Aide C and Nurse Aide D entered Resident #2's room to assist him/her to the bathroom. Observation revealed the 2 nurse aides pushed the resident, seated in a wheelchair, into the bathroom doorway and assisted the resident to pivot transfer to the commode. Nurse Aide D removed the resident's soiled incontinence pad from the resident's pants, then touched the resident's jacket with contaminated gloves. Nurse Aide C provided personal hygiene after the resident urinated, by using 3 wet wipes, folding each wipe over 3 times, and as he/she did this, the ends of his/her fingers touched the soiled area on the wipe. Continued observation revealed, Nurse Aide C obtained more wipes with his/her contaminated gloves on, and holding the wipe package with his/her contaminated gloved hand. Nurse Aide C then placed a clean incontinence pad, assisted the resident to pull his/her pants up, adjusted the resident's jacket, then removed his/her soiled gloves, and pushed the wheelchair from the bathroom into the resident's room. Nurse Aide D washed his/her hands and Nurse Aide C used hand sanitizer on his/her hands before leaving the resident's room.

On 8/29/16 at 5:59 PM, observation revealed Nurse Aide C prepared to assist Resident #3 to the bathroom. Nurse Aide C dropped 1 glove on the floor, near the bathroom doorway, picked up the contaminated glove and placed it on his/her hand, then applied a glove to the other hand. Nurse Aide C provided direction and assistance, using a gait belt and wheeled walker, as the resident walked into the bathroom, pulled down the resident's pants, and removed the soiled pull up, with his/her contaminated gloved hands. After

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finishing on the commode, the resident stood up and Nurse Aide C provided personal hygiene care with 3 wet wipes, cleaning front to back, with the contaminated gloves on. Nurse Aide C then applied a new incontinence brief to the resident, pulled the brief up and the pants up, and reapplied the resident shoes, still wearing the soiled gloves. Nurse Aide C then removed the soiled gloves, instructed the resident to walk forward, and Nurse Aide C used hand sanitizer on his/her hands, prior to assisting the resident to walk with the gait belt and wheeled walker out of his/her room.

On 8/29/16 at 5:36 PM, Nurse Aide D verified he/she did not remove his/her gloves after they became contaminated, and continued to provide care to the resident.

On 8/29/16 at 6:05 PM, Nurse Aide C stated, soiled gloves would be removed after being contaminated. Nurse Aide C verified he/she did not remove his/her gloves after they became contaminated.

On 8/29/16 at 6:10 PM, Nurse B verified each resident required assistance with incontinence care and the aides should wash hands before entering/exiting the room and gloves should be changed after becoming contaminated.

On 8/30/16 at 4:50 PM, Administrative Nurse A verified the aides should wash hands upon entering and prior to leaving the resident's room, and change gloves after being contaminated.

The facility's 12/06 Standard Precautions policy and procedure directed staff to:
Wash hands immediately after gloves are

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removed, between resident contacts, and when otherwise indicated to avoid transfer of microorganisms (a single cell life form that can only be seen with a microscope) to other residents or environments. Wash hands between tasks and procedures on the same resident to prevent cross- contamination of different body sites.
Wear gloves (clean, non-sterile) when touching blood, body fluids, secretions, excretions, and contaminated items.
Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms.
Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments.

The facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection, when staff failed to wash their hands upon entering a resident room, prior to performing direct care and did not remove his/her gloves after becoming contaminated for Resident #2, and Resident #3, placing the residents at risk for infection.