STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175157	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Andover	621 W 21st Andover, KS 67002

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 90 residents. The sample included three residents reviewed for falls. Based on observation, record review, and interviews, the facility failed to ensure an environment free from preventable accidents for Resident (R) 1. On 04/30/24, Certified Nurse Aide (CNA) M was providing incontinence (lack of voluntary control over urination or defecation) care for R1 when she noticed R1 was close to the edge of the bed. She moved her hand to wipe R1's buttocks and R1 rolled off the bed onto the floor. R1 was sent to the Emergency Department (ED) for evaluation and treatment where he received 13 staples for a laceration to his scalp because of the fall. The deficient practice also placed the resident at risk for increased pain and a further decline in mobility. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (cerebrovascular accident [CVA]- the 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), quadriplegia (paralysis of the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), lack of coordination, and generalized muscle weakness. The Annual Minimum Data Set (MDS) dated [DATE], documented R1 had short-term and long-term memory problems and his cognitive skills for daily decision-making were severely impaired. R1 had impairment on both sides of the upper and lower extremities. R1 was dependent on staff for activities of daily living (ADLs). R1 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag) and was always incontinent of bowel movements. R1 had no falls since the last assessment. The Quarterly MDS dated [DATE], documented R1 had short-term and long-term memory problems, and his cognitive skills for daily decision-making were severely impaired. R1 had impairment on both sides of the upper and lower extremities. R1 was dependent on staff for ADLs. R1 had an indwelling catheter and was always incontinent of bowel movements. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 03/14/24, documented R1 had cognitive-communication deficits related to memory problems and risk factors included self-care deficits, falls, and incontinence. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Urinary Incontinence and Indwelling Catheter CAA dated 03/14/24, documented R1 had a foley catheter (indwelling catheter) which placed him at risk for infection and injury if it dislodged. R1's Care Plan dated 01/08/19, documented R1 had an ADL self-care performance deficit related to CVA with deficits, bilateral upper and lower extremity contractures (abnormal permanent fixation of a joint), and quadriplegia. The plan documented an intervention, revised 09/21/22, that directed R1 was totally dependent on one to two staff for repositioning and turning in bed on rounds and as necessary. The plan documented an intervention, revised on 04/21/23, that R1 was dependent on one staff for incontinence care. R1's EMR revealed an Event Note on 04/30/24 at 11:04 PM. The note documented the nurse was notified that R1 was on the floor. Upon entering R1's room, R1 was lying on the floor, facing the window with his head bleeding. CNA M stated she assisted R1 when he rolled over, and he fell when she reached for wipes from the other side. R1 had an open area on the upper head that was bleeding and the nurse applied pressure to the wound to stop the bleeding. Staff helped R1 off the floor and called Emergency Medical Services (EMS) to transfer R1 to the ER for further evaluation. R1's EMR revealed Discharge Instructions, dated 05/01/24, for his ED visit on 04/30/24. The instructions documented R1 had a scalp laceration and was to return to the ED in 10 days for staple removal. The facility's investigation, dated 05/07/24, documented on 04/30/24 at approximately 09:30 PM, CNA M went to R1's room to provide perineal (the region of the body between the anus and the genital organs) care. CNA M stated she attempted to clean bowel movement off R1 when she noticed he was close to the edge of the bed. She stated when she moved her hand to wipe R1's buttocks, he rolled off the side of the bed onto the floor. CNA M immediately notified Licensed Nurse (LN) G. LN G reported when he entered R1's room, R1 was lying on the floor with his head bleeding. LN G performed first aid and applied gauze to the laceration on the top of R1's scalp. LN G obtained orders from the on-call physician to send R1 to the ED for further evaluation. R1 returned to the facility after receiving 13 staples to the midline of his scalp. In an undated Witness Statement, CNA M stated on 04/30/24 around 09:15 PM, she assisted R1 by changing him. She stated she was told by another CNA that R1 was a one-person assist, so she went to change him. CNA M stated she was holding onto R1 while trying to clean bowel movement off him and noticed he was close to the edge. She stated she moved her hand to wipe R1 and he rolled off the side of the bed. CNA M stated she told LN G what happened, and he assisted with R1. On 06/25/24 at 01:30 PM, R1 lay in bed, positioned on his right side with his eyes closed. On 06/25/24 at 01:49 PM, LN H stated after R1 fell out of bed on 04/30/24, there was an investigation and education was completed. She stated he now required two staff with bed mobility and incontinence care. LN H said R1 was stiff and contracted and he was difficult to move so it was better to have two staff. On 06/25/24 at 02:08 PM, Administrative Nurse D stated after R1 fell out of bed, staff were educated to make sure the resident was closer to the staff before turning the resident. She stated R1 required one to two staff with bed mobility but was changed to two staff with bed mobility after the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/25/24 at 02:58 PM, CNA N stated if a resident was heavy or on the edge of their bed, there should be two staff. She stated she had access to the care plan which had bed mobility requirements. CNA N stated two staff provided bed mobility with R1. She stated if she rolled a resident over and noticed they were on the edge of the bed, she laid them back down and got assistance. On 06/25/24 at 03:04 PM, LN I stated the care directive on the tablets and the care plan directed staff on resident assistance in bed. She stated if the resident was on the edge of the bed when rolled over, the staff brought the resident back to the middle of the bed and got assistance to prevent them from rolling off the bed. On 06/25/24 at 03:07 PM, Administrative Nurse D stated the Kardex (a nursing tool that gives a brief overview of the care needs of each resident) directed the level of assistance with bed mobility and positioning. She stated she expected staff to pull the resident over to them to give them plenty of room to turn the resident. Administrative Nurse D stated she expected staff to know their own and the resident's limits, follow the Kardex, and ask for help for residents the staff did not know. On 07/01/24 at 11:51 AM, CNA M stated on 04/30/24, she asked one of the CNAs if R1 required one-person or two-person assistance and she was told he required one-person assistance. She stated R1 was in the middle of the bed facing the wall and she had her hand on him, but she could not reach his call light. CNA M stated she tried to reach for a wipe and R1 rolled off the bed. She stated she noticed he was close to the edge of the bed when she started incontinence care. She stated he did not move because he was contracted, and she did not know how to explain what happened. The facility's Fall Management policy, revised 04/07/22, directed an avoidable accident occurred when the facility failed to implement interventions including adequate supervision consistent with the resident's needs, goals, care plan, and current professional standards in practice to eliminate the risk of an accident. The facility's Activities of Daily Living policy, revised 02/12/24, directed for bed mobility, staff utilized appropriate safety measures and any necessary equipment to maintain resident safety. The facility failed to prevent a fall with injury for R1. The deficient practice also placed the resident at risk for increased pain and a further decline in mobility. The facility put the following corrections into place by 05/11/24: R1 went to the ER for evaluation and treatment on 04/30/24. R1's Care Plan was updated to include two staff for repositioning and turning in bed on 05/05/24. Staff received education on safe transfers/fall prevention from 05/01/24 to 05/11/24. Due to the corrective actions completed prior to the onsite survey, the deficient practice was cited as past noncompliance, with the scope and severity of G.