STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175323	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare	412 E Walnut St Nortonville, KS 66060

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47834 The facility identified a census of 23 residents and 30 active resident trusts accounts, held by the facility. The sample included nine residents. Based on observation. Interviews, and record review, the facility failed to hold, safeguard, and manage Resident (R)4's trust fund as required when the facility failed to obtain appropriate authorization to disperse or use monies from R4's trust fund. This placed R4 at risk for impaired rights and potential misappropriation. Findings included: - R4's Quarterly Minimum Data Set (MDS) dated [DATE] documented R4 had severely impaired cognition. Review of R4's trust transactions as listed on the Resident Statement Landscape revealed a personal need items debit of $124.61 dated 07/15/24 and a personal need item debit of $300.00 dated 07/18/24. A Withdrawal Receipt with a receipt number W000215 for record number 00006 dated 07/12/24 listed an amount of $124.61 for personal needs items. The receipt included a handwritten note that indicated the resident was unable to sign the receipt, but the resident's durable power of attorney (DPOA) approved. An untitled document included a scanned copy of a Walmart receipt dated 07/12/24 that listed multiple items totaling $124.61 were purchased. The receipt indicated an attempt to purchase a debit card and load with $300. 00 was denied and voided. This same document included a scanned image of a trust account check 4776 with a handwritten total of $124.61 and a notation that would not allow to purchase a debit card. A Withdrawal Receipt with receipt number W000228 record number 071824 dated 07/17/24 recorded an amount of $300.00 for personal needs items. The receipt included the resident's signature and a handwritten note to buy a debit card so she can order on line w/assist. Upon request, the facility provided an untitled document with a scanned copy of a Walmart receipt dated 07/18/24 for the purchase of a money card in the amount of $300.00 for a total of $301.00. Observation of the facility's safe holding box on 08/22/24 at 05:11 PM revealed an unopened prepaid money card with the serial number that matched the 07/18/24 Walmart receipt. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/24 at 02:47 PM R4's DPOA stated she was informed by the facility that R4 had lost weight and needed new clothes so the clothing charges for $124.61 were authorized. R4's DPOA stated she was unaware of the purchase of a debit card and verified she had not authorized the debit card purchase or the amount of $300.00. R4's DPOA said that there was no way R4 could sign for anything or use a debit card to order anything. R4's DPOA verbalized concern that R4 might get taken advantage of because she had dementia (a progressive mental disorder characterized by failing memory and confusion). On 08/22/24 at 04:47 PM Administrative Staff B stated the facility should always obtain and annotate DPOA approval of any expenditures from eh resident's trust fund if the resident is cognitively impaired. She stated she thought Administrative Staff C had obtained permission to do a spend down and got permission to buy the debit card to order some bras. The untitled, undated policy provided by the facility documented each one of the facility's residents has the has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges the Facility may impose against a resident's personal funds. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility shall act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this policy. The facility will ensure, through established systems in place, safeguarding against any misappropriation of a resident's funds. The facility failed to hold, safeguard, and manage R4's trust fund as required when the facility failed to obtain appropriate authorization to disperse or use monies from R4's trust fund. This placed R4 at risk for impaired rights and potential misappropriation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 47834 The facility identified a census of 23 residents and 30 active resident trust fund accounts. The sample included nine residents. Based on record review and interview, the facility failed to distribute quarterly statements to all residents that held trust fund accounts in the facility. This placed the residents at risk for uninformed decisions regarding their trust fund and misappropriation. Findings included: - Review of the Trial Balance as of 08/21/24 revealed 30 total accounts with a balance of $63,621.38. The Trial Balance documented R5 had a current trust fund balance of $3705.47. On 08/26/24 at 02:04 PM, R5's representative and responsible financial party stated she has never received a quarterly statement regarding R5's trust account. She stated she has made inquiries into any remaining balances from R5's trust account since R5 discharged in March 2024 but she has not received any answers or account balances. On 08/26/24 at 02:40 PM Administrative Staff C confirmed that she has never sent out any quarterly statements for any of the trust accounts at the facility. She stated she had not yet received training regarding quarterly statements. Administrative Staff C said she has not received any inquiries regarding balances of trust accounts for discharged residents. The untitled and undated facility policy documented the Facility makes available to its residents individual financial records through quarterly statements and upon request. The quarterly statements shall be provided in writing to the resident or the resident's representative within 30 days after the end of the quarter, and upon request. The facility failed to distribute quarterly statements to all residents that held trust fund accounts in the facility. This placed the residents at risk for uninformed decisions regarding their trust fund and misappropriation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47834 The facility identified a census of 23 residents and 30 active resident trust fund accounts. The sample included nine residents. Based on record review and interview, the facility failed to ensure the conveyance of personal funds within 30 days of discharge and/or death for Resident (R) 5, R6, R7, R8 and R9. This placed the residents at risk for impaired rights and misappropriation. Findings included: - Review of the Trial Balance as of [DATE] revealed 30 total accounts with a balance of $63,621.38. The Trial Balance documented R5 had a current trust fund balance of $3705.47. R5's Electronic Medical record (EMR) recorded R5 discharged from the facility on [DATE]. The Trial Balance documented R6 had a current trust fund balance of $8342.61. R6's EMR recorded she died in the facility on [DATE]. The Trial Balance documented R7 had a current trust fund balance of $20.46. R7's EMR recorded he died in the facility on [DATE]. The Trial Balance documented R8 had a current trust fund balance of $21.02. R8's EMR recorded he died in the facility on [DATE]. The Trial Balance documented R9 had a current trust fund balance of $79.89. R9's EMR recorded he died in the facility on [DATE]. On [DATE] at 02:04 PM, R5's representative and responsible financial party stated she has never received a quarterly statement regarding R5's trust account. She stated she has made inquiries into any remaining balances from R5's trust account since R5 discharged in [DATE] but she has not received any answers or account balances. On [DATE] at 02:40 PM Administrative Staff C stated that she was not entirely certain what she was supposed to do with residents' trust funds when the resident died . She said, when a resident died in the facility, she typically called the family and asked what funeral home and wrote a check to the funeral home and closed out the account. Administrative Staff C said that for resident accounts that were old, from last year or many months ago, she was scheduled for training on how to convey those funds. Administrative Staff C said when a resident transferred to a different facility, she wrote a check to the resident or their family and closed out the trust. When asked about the resident that had transferred and still had a trust, she stated that must have occurred before knew what to do with the trust accounts. Administrative Staff C said she has not received any inquiries regarding balances of trust accounts for discharged residents. (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The untitled and undated facility policy documented upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility shall convey within 30 days, the resident's funds, and a final accounting of those funds, to the resident, his or her legal representative, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. The facility failed to ensure the conveyance of personal funds within 30 days of discharge and/or death for R5, R6, R7, R8 and R9. This placed the residents at risk for impaired rights and misappropriation.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 23 residents. The sample included nine residents. Based on record review and interviews, the facility failed to immediately respond to a change in health status and failed to obtain physician involvement when Resident (R) 1 had a critical lab result and subsequently developed abnormal blood pressure, lower than the physician ordered parameter. The facility further failed to immediately act upon the resident and/or his representative's request to seek acute care for treatment of his declining health situation. On 08/13/24, R1 fell from a full body lift during transfer. On 08/14/24, R1 complained of intermittent back pain and shakiness. On 08/15/24, a laboratory technician notified Licensed Nurse (LN) H of R1's critical creatinine (lab test used to measure how well the kidneys performed their job of filtering waste from the blood) level at 10:50 AM. LN H entered a late entry note on 08/16/24 at 08:43 AM which indicated she called Consultant GG who gave orders on 08/15/24 at 11:37 AM to increase fluids one to two liters and recheck labs on the following Monday. LN H entered the increased fluid order into R1's EMR at 03:58 PM but staff did not keep track of his increased fluid intake. LN H continued neurological assessments related to the fall from the lift and staff noted that R1 spoke like he had a thick tongue and could not grip with his left hand. At 04:30 PM, R1's blood pressure was 88/64 millimeters of mercury (mmHg). The facility did not notify R1's physician of the low blood pressure. At 07:34 PM, R1's blood pressure dropped further to 72/65 mmHg. R1's representative called LN G and requested staff send R1 to the hospital. LN G stated to R1's representative that if they sent R1 to the hospital and they did not admit him, the facility would have difficulty transporting R1 back. R1's representative contacted Program of All-Inclusive Care for the Elderly (PACE), and PACE called the facility and instructed staff to send R1 to the hospital. Emergency Medical Services (EMS) received the 911 call at 08:33 PM. EMS reported R1's blood pressure as 60/40 mmHg and they administered fluids on the way to the hospital. The hospital admitted R1 with diagnoses of an acute kidney injury (sudden and often reversible reduction in kidney function) and dehydration. R1 currently remained in the Intensive Care Unit (ICU). The facility's failure to respond immediately to a critical lab value and a decline in health status including abnormally low blood pressures and the failure to notify and inform the physician of R1's changing status placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of acquired absence (amputation) of left leg above knee, heart failure (a condition with low heart output and the body becomes congested with fluid), and hemiplegia (paralysis of one side of the body) affecting the right dominant side. The Annual Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 required staff dependency for chair/bed-to-chair transfers. The Quarterly MDS dated [DATE], documented R1 had a BIMS score of 14, which indicated intact cognition. R1 required staff dependency for chair/bed-to-chair transfers. The Functional Abilities Care Area Assessment (CAA) dated 11/17/23, lacked an analysis of findings. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Care Plan, dated 01/12/21, documented R1 had an activities of daily living (ADL) self-care performance deficit and directed R1 required total assistance with a Hoyer lift (full body mechanical lift) to move between surfaces and as necessary. R1's EMR revealed Special Instructions that directed staff to notify R1's physician if the resident's vital signs were outside of parameters which included: systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) greater than 180 mmHg or below 90 mmHg; diastolic blood pressure (DBP- minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) greater than 100 mmHg or below 50 mmHg. Certified Medication Aide S's Investigation Statement of Facts on 08/16/24, documented on 08/15/24 at approximately 07:00 PM, LN H asked her to assist in obtaining R1's vital signs per his representative's request. She stated it took about 20 minutes to obtain vital signs due to low blood pressure readings. LN H stated at approximately 07:30 PM to 07:45 PM, LN H called the doctor who gave an order to send R1 to the emergency room (ER). CMA S stated EMS arrived around 08:30 PM to 08:45 PM. LN G's Investigation Statement of Facts on 08/16/24, documented on 08/15/24, he received report that R1's had low blood pressure and staff monitored it. He stated at approximately 07:30 PM, he received a call from R1's representative that she wanted R1 sent to the hospital. LN G stated he told R1's representative he needed permission from the provider as soon as he hung up, PACE called and said to send R1 to the ER. He stated he called EMS at approximately 08:00 PM and they showed up about 30 to 45 minutes later. LN G stated EMS told him if they could not bring R1's blood pressure up, they would go to a closer hospital. R1's medical record revealed the following: An Incident Note on 08/13/24 at 02:07 PM documented at approximately 12:45 PM, two Certified Nurse Aides (CNAs) were in R1's room preparing him for his shower. They had R1 up in the air with the Hoyer lift when the sling came loose, causing R1 to fall to the floor. The CNAs stated R1 hit the lower part of his back on one of the lift legs. When the nurse entered the room, R1 laid flat on his back and voiced extreme low back pain. R1 had abrasions and several skin tears noted to the top of his right forearm. The nurse did not assess R1's back due to waiting for paramedics to arrive. R1 transferred to the ER for evaluation and treatment at approximately 01:30 PM. A Nurse Note on 08/13/24 at 10:28 PM documented R1 returned to the facility. Computed Tomography (CT scan- test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) scan of R1's lumbar and thoracic spine were negative. Staff received no new orders. A Psychosocial Note on 08/14/24 at 11:32 AM documented Social Services X spoke to R1. R1 stated his whole body hurt after the Hoyer lift fall. R1 expressed fear of using the Hoyer lift in the future. Social Services X noted R1 appeared tearful when speaking about the incident. Social Services X planned to follow up on a daily basis as long as R1 needed. A Nurse Note on 08/14/24 at 02:08 PM documented R1 spent the day in bed per his normal. R1 voiced occasional back pain and received as needed (PRN) Tylenol (pain medication) and PRN Oxycodone (pain medication). R1 stated he felt shakier than usual, and he felt tired. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Basic Metabolic Profile (BMP- lab test to help doctors check the body's fluid balance, level of electrolytes, and kidney function) on 08/15/24 at 07:35 AM documented a critical creatinine level of 4.33 milligrams per deciliter (mg/dL, with a reference range of 0.80 to 1.30 mg/dL) with a note at 10:50 AM that the lab technician notified LN H of the critical lab level. A Health Status Note on 08/15/24 at 11:37 AM, late entered on 08/16/24 at 08:43 AM, documented LN H received a call from the laboratory with R1's critical creatinine lab value of 4.33 mg/dL. LN H notified Consultant GG and received a call back with orders to increase R1's fluids one to two liters in the next 24 hours and repeat labs on 08/19/24. A Psychosocial Note on 08/15/24 at 01:03 PM documented Social Services X spoke to R1 in his wheelchair. Staff moved R1 from his bed to his chair via Hoyer lift. R1 complained of pain but he no longer voiced fear of using the lift. R1's EMR documented R1's blood pressure on 08/15/24 at 04:30 PM was 88/64 mmHg. A Nurse Note on 08/15/24 at 07:35 PM, late entered on 08/16/24 at 02:41 PM, documented LN G sent R1 by ambulance to the hospital per R1's representative and PACE request. R1's blood pressure was 72/65 mmHg, pulse was 65 beats per minute (bpm), and respirations were 16. R1 identified himself, place, and situation at time of transfer. An Emergency Department Note on 08/15/24 at 09:51 PM documented R1 presented to the ER with a complaint of low blood pressure and the facility reported a blood pressure of 70/69mmHg at 06:00 PM. R1 arrived at the ER at 09:45 PM. EMS reported they obtained 60/40 mmHg as R1's blood pressure and gave him 500 milliliters (mL) of normal saline with an increase to his blood pressure to 95/60 mmHg. R1 was awake and alert and only complained of low back pain. R1's temperature was 91.6 degrees F rectally. R1 was admitted for observation for slow hydration. A Nurse Note on 08/16/24 at 05:48 AM documented R1 admitted to the ICU with a temperature of 90 degrees Fahrenheit (F) and a systolic BP between 70 and 100 mmHg. An Internal Medicine Progress Note on 08/17/24 at 12:01 PM documented R1 admitted with hypotension (low blood pressure) due to sepsis (a systemic reaction that develops when the chemicals in the immune system release into the blood stream to fight an infections which cause inflammation throughout the entire body instead. Severe cases of sepsis can lead to the medical emergency, septic shock) and hypovolemia (low blood volume). R1 required medication to increase his blood pressure the day before but tapered off at 03:30 AM that morning. R1 produced urine better as well. R1 voiced he was still sore all over from his recent fall. R1 was critically ill and at a high risk of adverse outcomes from severe sepsis and although he improved, he likely needed a prolonged hospital stay to stabilize. R1's representative did not want R1 to return to the facility to which R1 agreed with wholeheartedly . An Internal Medicine Progress Note on 08/18/24 at 10:00 AM documented R1 admitted with hypotension due to sepsis and hypovolemia on the evening of 08/15/24 and moved to the ICU on the morning of 08/16/24. R1 downgraded to the medical/surgical unit yesterday afternoon. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/21/24 at 12:50 PM, LN G stated when he started his shift on 08/15/24, LN H reported a concern about R1's blood pressure dropping. He stated he took R1's blood pressure shortly after his shift started, around 06:10 PM, and his blood pressure was about 73/48 (mmHg). LN G stated LN H told him to monitor R1 and give him fluids. He stated he went to recheck R1's blood pressure again, around the same time R1's representative called. LN G stated R1's representative wanted R1 sent to the hospital, and he informed her he needed to call someone, and the facility had a hard time getting residents back if they did not get admitted to the hospital. LN G stated he received a call from PACE who instructed him to send R1 to the hospital. He stated he called EMS for R1, and they arrived to the facility. He stated EMS stated to him that if they were unable to get R1's blood pressure up then they would transport him to a closer hospital. LN G stated R1's blood pressure started dropping around 04:30 PM but he already had an order to increase fluids due to a critical creatinine level. He stated if the nurse notified the physician, the nurse documented the notification in the notes. LN G stated R1 did not initially want to go to the hospital but staff convinced him to go. He stated, usually staff notified the physician as soon as a change in condition occurred or a resident's status started to change. During an interview on 08/21/24 at 01:27 PM, Administrative Nurse D stated on 08/15/24, Social Services X reported to her that R1 looked a little different and told her he could not grip with his left hand. Administrative Nurse D stated she talked to R1, and he seemed to be talking with a thick tongue. She stated she had not heard anything else about R1 until LN G notified her at 08:06 PM that he needed to print off paperwork for R1 to go to the hospital. She stated LN G texted her at 09:27 PM that EMS reported to him they were transporting R1 to a closer hospital due to being unable to increase his blood pressure. Administrative Nurse D stated LN H passed on in report to LN G that R1's blood pressure had been low and to monitor it. She stated R1's representative called at 07:30 PM and requested LN G to send R1 to the hospital but LN G seemed hesitant and made a comment that if the hospital did not admit R1, it would be difficult to get R1 back to the facility. Administrative Nurse D stated LN G got off the phone and PACE called the facility and advised him to send R1 to the hospital. She stated she received a text from the CMA S at 07:52 PM that R1 did not really want to go to the hospital but they convinced him to go. Administrative Nurse D stated LN H should have notified the physician of R1's low blood pressure at 04:30 PM and LN G should have notified the physician of his low blood pressure after shift change. She stated she expected staff to document physician notifications in the progress notes and if they had a conversation with the resident about his desire to not go to the hospital, it should be documented as well. She stated if a resident or resident's representative requested the resident go to the hospital, she expected staff to notify the physician and tell them the resident was going out to the hospital. Administrative Nurse D stated she would rather EMS arrived to watch the resident and have to wait for paperwork than the nurse gather paperwork before the facility called EMS. During an interview on 08/21/24 at 01:59 PM, county dispatch stated the facility called for EMS on 08/15/24 at 08:33 PM related to a resident with low blood pressure and dispatch sent EMS out a couple of minutes later. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/21/24 at 02:38 PM, LN H stated on 08/15/24, she continued follow-up fall vital signs. She stated the CMA checked R1's blood pressure and reported it as being low. LN H stated she rechecked it and it was not low. She stated around lunch, R1 complained of being achy and she gave him oxycodone for pain. LN H stated she received a call back from PACE because she had called to notify them of R1's critical creatinine level. PACE told them they would call back after notifying Consultant GG. LN H stated PACE called back about 15 minutes later and directed her to push one to two liters of fluid over the next 24 hours and monitor R1. She stated around 04:30 PM, she checked his vital signs and R1's blood pressure was low again. LN H stated she reported to LN G during shift change that R1 had low blood pressure, and LN G needed to check it again after report. She stated LN G replied, he would recheck R1's blood pressure and would probably send R1 out if he had low blood pressure. LN H stated she put in the increased fluid order but did not document R1's fluid intake. She stated she did not notify R1's provider of his low blood pressure at 04:30 PM because it was only low once for her and the night nurse said he would check R1's blood pressure again. She stated if she had rechecked R1's blood pressure before the end of her shift and it was low, she would have thought about calling R1's physician. LN H stated she documented physician notifications in the progress notes. The facility's Acute Condition Changes- Clinical Protocol policy, revised 07/05/24, documented that staff contacted the physician based on the urgency of the situation and the attending physician responded in a timely manner to the notification of problems or changes in condition or status. The policy directed staff to monitor and document the resident's progress and responses to treatment. The policy directed the physician to review the status of the condition change and document their evaluation at the next visit. The facility failed to immediately respond to a change in health status and failed to obtain physician involvement when R1 had a critical lab result and subsequently developed abnormal blood pressure lower than the physician ordered parameter. The facility further failed to immediately act upon the resident and/or his representative's request to seek acute care for treatment of his declining health situation. R1 currently remained in the ICU. The facility's failure to respond immediately to a critical lab value and a decline in health status including abnormally low blood pressures and the failure to notify and inform the physician of R1's changing status placed R1 in immediate jeopardy. On 08/21/24 at 04:20 PM Administrative Staff A received a copy of the Immediate Jeopardy Template and was informed of the facility's failure to respond to and involve the physician in R1's change in condition, including a critical lab value with low blood pressures, placed R1 in immediate jeopardy. The facility submitted an acceptable plan for removal of the immediacy on 08/21/24 at 08:44 PM, which included the following: All current nurses, CMAs, and Certified Nurse Aides (CNAs), and applicable agency staff were educated on the following starting on 08/22/24: How to identify and respond to changes in condition Honoring a residents/responsible party right to direct their own healthcare. Notification of changes to the resident, responsible party and physician. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare	412 E Walnut St Nortonville, KS 66060

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	How to respond, according to standard, related to critical labs. Blood pressure parameters and when to notify or act. All current residents had a chart review no later than 08/22/24 to ensure blood pressure parameters were noted within the clinical record. This was the responsibility of the Director of Nursing, with oversight by the Regional Nurse Consultant. All current residents, who had a clinical order for fluid monitoring, would have an additional task added to their record-to-record fluid intake. This occurred by 08/22/24. This task was the responsibility of Administrative Nurse D with oversight by the Regional Nurse Consultant. All current residents had chart reviews completed by 08/22/24 to ensure currently ordered labs were in the clinical record and a full assessment to identify the labs were drawn, report was received, and the resident, responsible party and physician were notified. This was the responsibility of the Director of Nursing with oversight by the Regional Nurse Consultant. The surveyor verified the implementation of the above immediacy removal plan while onsite on 08/22/24 at 05:35 PM. The deficient practice remained at a scope and severity of G, to reflect the actual harm experienced by R1.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47834 The facility identified a census of 23 residents. The sample included nine residents. Based on record review and interviews, the facility failed to provide Resident (R) 2 with wound care consistent with standards of practice when staff failed to ensure physician involvement for wound status changes and appropriate treatment orders, and failed to assess wound characteristics consistently and when treatment changes were made. These failures resulted in the deterioration of the wound and the worsening of the infectious process. This also placed R2 at risk for increased pain and other wound-related complications. Findings included: - R2's Electronic Medical Record (EMR) documented a diagnosis of cerebral infarction (stroke - 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), pressure-induced deep tissue damage (pressure ulcer - localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of the sacral region (sacrum - large triangular bone/area between the two hip bones), open wound of lower back and pelvis, weakness, systolic congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). The Admission Minimum Data Set (MDS), dated [DATE], noted R2 had problems with short-term and long-term memory. The MDS further documented R2 had poor decision-making and required cues and supervision. The MDS documented R2 used a wheelchair and required substantial, maximal assistance for transition from lying to a seated position on the edge of a bed, sitting to stand, bathing, toileting hygiene, lower body dressing, and transfers. The MDS documented R2 was on antibiotics and had one stage four (a deep pressure wound that reaches the muscles, ligaments, or even bone) pressure ulcer. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 07/18/24, documented R2 had obvious long- and short-term memory deficits. The CAA documented R2 was admitted to the facility following a hospital stay secondary to a sacral wound with infection and was on intravenous (IV- administered directly into the bloodstream via a vein) antibiotics. The CAA further documented R2 required assistance with ADL completion and had a wound vacuum-assisted closure device (wound vac - a wound healing therapy that uses negative pressure to help wounds heal) in place to his sacral area. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R2's Care Plan, with an initiated date of 07/23/24, documented R2 had a stage four pressure ulcer to his sacrum. An intervention with an initiated date of 07/23/24 documented R2 had a wound vac to his sacral wound. Staff were to change the resident's wound vac three times a week and as needed. An intervention with an initiated date of 07/23/24 directed staff to assess, record, and monitor wound healing weekly and as needed. Measure the wound length, width, and depth where possible. Assess and document the status of the wound perimeter, wound bed, and healing progress. Report improvements and declines to the doctor (MD). An intervention with an initiated date of 07/23/24 directed staff to administer treatments as ordered and monitor for effectiveness. An intervention with an initiated date of 07/23/24 directed staff to monitor the dressing every shift to ensure it was intact and adhering, report loose dressing to the treatment nurse, and replace wound vac as needed. An intervention with an initiated date of 07/23/24, documented weekly treatment documentation was to include measurement of each area of skin breakdown's width, length, depth, type of tissue, and exudate (the fluid that leaks out of body vessels and tissues). R2's Care Plan, with an initiated date of 07/23/24, documented R2 had an infection of his sacral wound. An intervention with an initiated date of 07/23/24, directed staff to change wound vac dressing three times a week and as needed. R2's Care Plan, with an initiated date of 08/08/24, documented R2 had actual impairment to skin integrity of the skin surrounding the pressure ulcer related to a possible reaction to Tegaderm (transparent, film dressing that can be used to protect wounds) that secured the wound vac. An incomplete intervention with an initiated date of 08/08/24 documented R2 needed (SPECIFY: pressure relieving/reducing mattress, pillows, sheepskin padding, etc.) to protect the skin while in bed. R2's EMR documented the following: An Admission Note dated 07/12/24 documented R2 was oriented to his room and the facility. The note further documented R2 had a wound vac placed and medications ordered to start IV antibiotics in the morning. A Nursing: Weekly Skin Evaluation dated 07/14/24, documented R2 had an open wound to the sacrum. The evaluation description related to the sacral wound documented tunneling (a wound that's progressed to form passageways underneath the surface of the skin) pressure ulcer, with a wound vac in place. The evaluation lacked further sacral wound evaluation including peri-wound (skin surrounding the wound), drainage, odor, and other signs of infection, and wound measurements related to the sacral wound. A Physician's Order with a start date of 07/15/24, documented to change the sacral wound vac, settings: 150 (negative pressure) continuous. Three times weekly on the day shift and as needed. Every Monday, Wednesday, and Friday. (Order placed on hold 08/07/24) R2's EMR lacked an order or dressing instructions to staff in the event the wound vac malfunctioned or could not be placed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Weekly Pressure Injury Skin Report dated 07/17/24, documented R2 had a stage four pressure wound to his sacrum with a length of 6.5 centimeters (cm), width of 4.6 cm, and depth of 2.3 cm. The assessment documented a moderate amount of serosanguineous (semi-thick blood-tinged drainage) exudate, with no foul odor documented. The note described the wound bed as dark pink or red tissue with slough (dead tissue, usually cream or yellow in color). The note further documented the surrounding skin as normal for skin, and the assessment was marked as no change from the previous assessment and directed to continue the current treatment as ordered. The comment box on the assessment was blank. A Weekly Pressure Injury Skin Report dated 07/24/24, documented R2 had a stage four pressure wound to his sacrum with a length of 6.5 cm, width of 4.6 cm, and depth of 2.3 cm. The assessment documented a moderate amount of serosanguineous exudate, with no foul odor documented. The wound bed was described as dark pink or red tissue with slough. The surrounding skin was documented as normal for skin, progress from the previous assessment was marked as no change and directed to continue the current treatment as ordered. The comment box on the assessment documented the site was beefy red with some minimal bleeding noted to the surrounding skin when the clear film dressing was removed. R2's EMR lacked evidence the changes and bleeding to the peri-wound was reported to the physician. A Weekly Pressure Injury Skin Report dated 07/26/24, documented R2 had a stage four pressure wound to his sacrum with a length of 6.5 cm, width of 4.6 cm, and depth of 2.3 cm. The assessment documented a moderate amount of serosanguineous exudate, with no foul odor documented. The wound bed was described as dark pink or red tissue with slough. The surrounding skin was documented as normal for skin, progress from the previous assessment was marked as no change and directed to continue current treatment as ordered. The comment box on the assessment was blank. A Weekly Pressure Injury Skin Report dated 07/31/24, documented R2 had a stage four pressure wound to his sacrum with a length of 6.5 cm, width of 4.6cm, and depth of 2.3cm. The assessment documented a moderate amount of serosanguineous exudate, with no foul odor documented. with the wound bed was described as dark pink or red tissue with slough. The surrounding skin was documented as normal for skin, progress from the previous assessment was marked as no change and directed to continue current treatment as ordered. The comment box on the assessment documented redness, with skin breakdown noted surrounding the wound. Skin-prep (liquid skin barrier) was applied. R2's EMR lacked evidence the physician was notified of the skin breakdown. A Nursing: Admission Eval dated 08/03/24, under section C skin evaluation, documented R2 had an unstageable pressure ulcer to his sacrum with a length of 6.0 cm, width of 4.0 cm, and depth of 2.0 cm. No further description of the sacral wound was documented in the assessment. A Nursing: Weekly Skin Evaluation dated 08/04/24, documented R2 had an open wound to his sacrum. The evaluation description related to the sacral wound documented a continued tunneling pressure ulcer with a wound vac in place. The evaluation lacked further sacral wound description and lacked wound measurements related to sacral wound. An Infection Note dated 08/05/24 at 03:41 AM noted R2 remained on IV antibiotics for the treatment of a wound infection. R2 had a wound vac in place on his sacrum. R2 did not have any adverse reactions to his medication. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Nurse Note dated 08/07/24 at 02:55 PM, documented the skin surrounding R2's pressure ulcer that was covered with Tegaderm had become reddened with areas of breakdown. The note documented that staff was unable to attach and seal the wound vac due to the area of breakdown. The note further documented the writer consulted with a certified wound nurse who recommended a treatment to use until the physician gave further orders. A Physician's Order with a start date of 08/07/24, documented a sacral dressing and directed to cover the wound bed with calcium alginate antimicrobial silver (dressing with antimicrobial properties used on infected wounds or wounds that are at a high risk of infection), apply Xeroform gauze (sterile non-adhering fine mesh gauze treated with a bacteriostatic agent) dressing, cover with ABD (large pad to absorb drainage) and paper tape. Change twice weekly until the resident could be seen by Veterans Affairs (VA). (This order was discontinued on 08/12/24). R2's August 2024 Medication Administration Record /Treatment Administration Record (MAR/TAR) lacked evidence the dressing was applied on 08/07/24 when initially ordered. The MAR/TAR recorded the dressing was first applied on 08/10/24 and then discontinued on 08/12/24. R2's EMR lacked evidence physician was contacted or made aware of R2's complications related to the wound vac and new dressing change order until 08/12/24. A Nursing: Weekly Skin Evaluation dated 08/10/24, documented R2 had an open wound to the sacrum. The evaluation description related to the sacral wound documented a continued tunneling pressure ulcer. The evaluation lacked further sacral wound description and lacked wound measurements related to sacral wound. A Health Status Note dated 08/12/24 at 09:58 AM documented Consultant HH was at the facility and saw R2. The note documented the plan of care was reviewed, new orders noted, and the dressing to R2's sacral area was changed to saline wet to wet twice daily (BID). A Physician's Order with a start date of 08/12/24, documented a sacral dressing, cleanse with wound cleanser then apply saline wet to wet to the wound; cover and change BID every day and night shift for wound. (Order placed on hold 08/19/24) A Weekly Pressure Injury Skin Report dated 08/14/24, documented R2 had a stage four pressure wound to his sacrum with a length of 6.5 cm, width of 4.6 cm, and depth of 2.8 cm. The assessment documented a moderate amount of serosanguineous exudate, with no foul odor documented. The wound bed was described as dark pink or red tissue with slough. The surrounding skin was documented as reddened, progress from the previous assessment was marked as deteriorated and noted to continue the current treatment as ordered. The comment box on the assessment documented dark red, and purple tissue surrounding the wound. R2's EMR lacked evidence the physician was notified of the changes in the wound and/or peri-wound. A Nursing: Weekly Skin Evaluation dated 08/17/24, lacked documentation related to R2's sacral wound and contained no wound measurements. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An Order Note dated 08/19/24, documented R2 had a decline in alertness, his blood pressure had decreased, and his pulse increased from his normal range. The note documented R2 refused to eat or drink much and his wound to the coccyx was black in color with a strong foul smell. Staff placed a call to the provider, and they gave an to send R2 to the emergency room . A Nurse Note dated 08/19/24 documented an ambulance arrived at the facility and transported R2 to the emergency room at 01:10 PM. R2's Emergency Department Note dated 08/19/24 recorded R2 presented to the emergency department for possible sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body). The note further documented R2's sacral wound measurements were approximately 10 cm by 14 cm, and the wound was necrotic (pertaining to the death of tissue in response to disease or injury) with tunneling present. On 08/21/24 at 03:40 PM, in a phone interview with Consultant JJ, a nurse for Consultant HH, Consultant JJ stated she reviewed all the call logs from 08/07/24 and stated that there were no logged calls from the facility on that day related to R2 at all. On 08/21/24 at 04:23 PM, Hospital Nurse II stated R2 admitted for sepsis. Hospital Nurse II stated R2's sacral wound was in very bad condition when he arrived. Hospital Nurse II stated R2's wound was really bad and showed signs of neglect. Hospital Nurse II confirmed R2 had transferred to another hospital for a higher level of care. On 08/22/24 at 03:33 PM, Licensed Nurse (LN) H stated she was unsure why R2's wound vac was removed, but said she believed it was related to the tape used on the wound vac and R2's skin breakdown around the site where the wound vac dressing was placed. LN H stated wound assessments were supposed to be completed weekly and that included assessing the wound and taking measurements. LN H further stated staff were supposed to measure the wounds to know if they were changing in size, assess tissue to note if the wound had worsened or improved, and know if the physician needed to be notified. LN H stated the last time she saw R2's wound, it was horrible and was deep enough to see his tailbone. LN H stated she would reassess a wound if new treatments or dressings were ordered. LN H stated she believe R2's wound began deteriorating after the wound vac was removed. She stated at first the site around the wound was pink; however, as time went on, staff believed the dressing was irritating R2's skin, and it gradually got worse, and the wound vac was removed. LN H stated she saw the wound when R2 first arrived at the facility and the wound had some small necrotic tissue around the opening; however, she stated it was much smaller and was not as severe. LN H stated she was off work for a week, and when she returned R2's wound had worsened. She stated she had been a nurse for [AGE] years and this was the first time she gagged after seeing the wound without the wound vac. LN H stated if staff notice a breakdown in a wound, especially after a new treatment was ordered, they should notify the provider. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 08/26/24 at 12:15 PM Administrative Nurse D stated if staff noticed a wound was worsening, she expected staff to notify her or their wound nurse as they handle the wound care for the facility. Administrative Nurse D stated she expected staff to assess wounds, which included taking measurements and documenting them weekly. Administrative Nurse D stated she believed the wound vac dressings for R2 were done three times per week. Administrative Nurse D stated if there was a change in dressing types, she expected staff to at least document a progress note as to why the wound vac could not be put back in place while waiting for the doctor to notify staff of a change in treatment. Administrative Nurse D stated R2's skin was breaking down; it was raw and would not stick to the dressing to form a seal. Administrative Nurse D stated staff believed the wound vac dressing would have caused more damage if put back on. Administrative Nurse D stated their wound nurse attempted to use barriers to help with the seal; however, it did not work. She stated she believed the cause of R2's issues were related to the tape, or Tegaderm and not the staff's competency. Administrative Nurse D stated Administrative Nurse E was in the facility the day the wound vac was removed and Administrative Nurse E was a certified wound nurse. Administrative Nurse D stated they followed Administrative Nurse E's recommendation to change the wound dressing twice weekly while waiting for the doctor to decide how he wanted to address it. Administrative Nurse D stated the doctor changed the dressing to a wet to wet while the facility awaited a response from the VA for approval. Administrative Nurse D stated no one had mentioned to her that R2's wound had worsened prior to him being sent out to the ER. On 08/26/24 at 01:44 PM Administrative Nurse E stated she was asked to assess R2's sacral wound, and that she understood the wound was previously debrided (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue) at a hospital prior to admission. Administrative Nurse E stated R2's wound was a wicked wound with slough and eschar (dead tissue) and a wound vac could not be done on a wound with eschar. Administrative Nurse E stated she believed R2 should have had his wound debrided again at the hospital; however, they had to await approval through the VA. Administrative Nurse E stated the doctor was called to get a new dressing order to get by until R2 could be seen at the VA. Administrative Nurse E stated there was 80% slough and eschar in R2's wound when she saw it. Administrative Nurse E stated she believed Administrative Nurse D contacted Consultant HH for the dressing order. Administrative Nurse E stated if staff contacted a physician, then that staff should document that. Administrative Nurse E stated if it was not documented, then it was not done. On 08/26/24 at 02:02 PM Administrative Nurse D stated she consulted with Administrative Nurse E regarding R2's wound and wound vac issue. Administrative Nurse D stated she did not know who contacted Consultant HH to get an order for the dressing change on 08/07/24 when the wound vac was removed. Administrative Nurse D stated she was with Administrative Nurse E when Administrative Nurse E recommended the dressing change and gave it to the nurse. Administrative Nurse D stated she entered the dressing order into the system; however, she believed LN I was supposed to have contacted Consultant HH to get permission for the order. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 08/26/24 at 02:07 PM LN I stated she went to change R2's wound vac and his skin was broken down under the Tegaderm. LN I stated she cleaned and dried the site; however, the dressing would not adhere. LN I stated she did not have a lot of wound experience, so she got Administrative Nurse E and Administrative Nurse D for assistance. LN I stated Administrative Nurse E and Administrative Nurse D were going to get a hold of Consultant HH for an order until Consultant HH could come to see R2. LN I stated Administrative Nurse E recommended the twice-weekly order, and then Administrative Nurse D got ahold of Consultant HH to obtain the order. LN I said the following Monday, Consultant HH changed the dressing order to a wet-to-wet dressing twice daily. LN I stated she changed the dressing on 08/07/24. LN I stated she saw the wound when the wound vac was removed and was the nurse who sent R2 out to theER on [DATE]. LN I stated R2's wound looked worse. She stated R2's wound did not have necrotic skin when they removed the wound vac and the wound bed was a dark, deep red. LN I stated R2's wound later had blistering around the edges of the wound, was peeling, and had black spots in the wound bed. She further stated the wound had a stronger odor the day he was sent out. The facility's Wound Care policy with a revised date of 07/15/24, documented the following information should be recorded in the resident's medical record: the type of wound care given, the date and time the wound care was given, the name and title of the individual performing the wound care, any changes in the resident's condition, all assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound, any problems or complaints made by the resident related to the procedure, if the resident refused the treatment and he reasons why and the signature and title of the person recording the data. The facility failed to provide R2 wound care consistent with standards of practice when staff failed to ensure physician involvement for wound status changes and appropriate treatment orders, and failed to assess wound characteristics consistently and when treatment changes were made. These failures resulted in the deterioration of the wound and the worsening of the infectious process. This also placed R2 at risk for increased pain and other wound-related complications.

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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 23. The sample included nine residents. Based on record review and interviews, the facility failed to ensure Resident (R) 1 remained free from preventable accidents during a Hoyer lift (full body mechanical lift) transfer. This deficient practice resulted in impaired psychosocial well-being and placed R1 at risk for further complications. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of acquired absence (amputation) of left leg above knee, heart failure (a condition with low heart output and the body becomes congested with fluid), and hemiplegia (paralysis of one side of the body) affecting the right dominant side. The Annual Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 required staff dependency for chair/bed-to-chair transfers. The Quarterly MDS dated [DATE], documented R1 had a BIMS score of 14, which indicated intact cognition. R1 required staff dependency for chair/bed-to-chair transfers. The Functional Abilities Care Area Assessment (CAA) dated 11/17/23, lacked an analysis of findings. The Falls CAA dated 11/15/23, documented R1 required assistance with activities of daily living (ADLs). R1's Care Plan, dated 01/12/21, documented R1 had an ADL self-care performance deficit and directed R1 required total assistance with a Hoyer lift to move between surfaces and as necessary. Certified Nurse Aide (CNA) M's Investigation Statement of Facts, dated 08/13/24, documented she and Certified Medication Aide (CMA) R hooked R1 up to the Hoyer lift to transfer him to the shower chair. She stated one of R1's lift sling leads came unattached, and they thought it had ripped. CNA M stated R1 fell out of the sling, and they quickly got him off of the Hoyer lift leg to make sure he was okay while CMA R notified the nurse. The nurse assessed R1 and called EMS. CMA R's Investigation Statement of Facts, dated 08/13/24, documented she and CNA M put R1 in the Hoyer lift and as she started to turn around to put him in the shower chair, one side of the Hoyer lift sling snapped and R1 tipped while another sling loop slid off. R1 fell to the ground and his back landed on the Hoyer lift. R1's right arm bled, and CNA M covered it as she ran to get the nurse. R1 complained of back pain but they did not move him until the ambulance arrived. R1's medical record revealed the following: (continued on next page)

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	175323	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare	412 E Walnut St Nortonville, KS 66060

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An Incident Note on 08/13/24 at 02:07 PM documented at approximately 12:45 PM, two CNAs were in R1's room preparing him for his shower. They had R1 up in the air with the Hoyer lift when the sling came loose, causing R1 to fall to the floor. The CNAs stated R1 hit the lower part of his back on one of the lift legs. When the nurse entered the room, R1 laid flat on his back and voiced extreme low back pain. R1 had abrasions and several skin tears noted to the top of his right forearm. The nurse did not assess R1's back due to waiting for paramedics to arrive. R1 transferred to the emergency room (ER) for evaluation and treatment at approximately 01:30 PM. A Nurse Note on 08/13/24 at 10:28 PM documented R1 returned to the facility. Computed Tomography (CT scan- test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) scan of R1's lumbar and thoracic spine were negative. Staff received no new orders. A Psychosocial Note on 08/14/24 at 11:32 AM documented Social Services X spoke to R1. R1 stated his whole body hurt after the Hoyer lift fall. R1 expressed fear of using the Hoyer lift in the future. Social Services X noted R1 appeared tearful when speaking about the incident. Social Services X planned to follow up on a daily basis as long as R1 needed. A Nurse Note on 08/14/24 at 02:08 PM documented R1 spent the day in bed per his normal. R1 voiced occasional back pain and received as needed (PRN) Tylenol (pain medication) and PRN Oxycodone (pain medication). R1 stated he felt shakier than usual, and he felt tired. A Psychosocial Note on 08/15/24 at 01:03 PM documented Social Services X spoke to R1 in his wheelchair. Staff moved R1 from his bed to his chair via Hoyer lift. R1 complained of pain but he no longer voiced fear of using the lift. The facility's Investigation, dated 08/19/24, documented on 08/13/24 at approximately 12:40 PM, CMA R and CNA M entered R1's room to perform a Hoyer lift transfer from his bed to the shower chair. One operated the lift while the other held the shower chair steady. As the staff lifted R1 up with the Hoyer lift, R1 requested them to check his weight. CNA M told R1 they would obtain his weight after his shower. As staff turned the Hoyer lift from the bed to the shower chair, R1 slid out of the Hoyer sling and onto the floor. CNA M and CMA R noted two of the Hoyer sling loops had popped off of the lift hooks. Staff immediately notified Licensed Nurse (LN) I. LN I called the ambulance and reported the incident to Administrative Nurse D and Administrative Staff A. Both CNA M and CMA R reported R1 hit his back on the leg of the lift and R1 complained of back pain. Staff noted R1 had a skin tear to his right arm. The facility received an order to send R1 to the emergency room (ER) for evaluation. The hospital performed a CT scan on R1's back with no negative results. The hospital discharged R1 back to the facility with a diagnosis of mechanical low back pain. During the investigation, Administrative Nurse D, the Regional Nurse Consultant, and Administrative Staff A re-enacted the incident with CMA R and CNA M. During the re-enactment, CNA M and CMA R did not widen the Hoyer lift legs after they cleared the bed per manufacturer's instructions. As a result, the Hoyer lift became unsteady and R1 slid out of the Hoyer lift during the transfer. On 08/21/24 at 04:40 PM, Social Services X stated she went to R1's room on 08/14/24 to follow-up with him after the fall from the Hoyer lift. She stated R1 voiced being scared of the Hoyer lift and he appeared tearful and in pain. She stated on 08/15/24, she went to talk to R1 because he had been transferred to his wheelchair. She stated R1 was sometimes confused and because he did not mention being scared of the Hoyer lift, she did not remind him that he stated he was previously. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 08/21/24 at 05:16 PM, CNA N stated to prevent accidents with the Hoyer lift, staff placed the lift sling hooks and made sure the secondary hooks were in place too. She stated one staff operated the lift while the other stayed with the resident. CNA N stated the lift legs were closed under the bed and staff opened them up when moving the lift out from under the bed to steady the lift. She stated she completed lift competencies recently. On 08/22/24 at 02:24 PM, LN H stated two staff operated the Hoyer lift at all times and hooked up the same color loops of the lift sling to the Hoyer lift. She stated one staff operated the lift while the other guided the resident and staff opened the lift legs during the transfer for more support. On 08/22/24 at 05:35 PM, Administrative Nurse D stated she expected staff to use two people during Hoyer lift transfers, one to spot while driving the lift and the other to open the lift legs once they were clear of the bed. She stated she expected staff to have the correct sling size and correct sling placement. Administrative Nurse D stated she expected staff to use the appropriate sling lift loops and to make sure to use the back up loop on the sling. She stated staff used a shower lift sling with the Hoyer lift for R1's transfer. She stated one of the failures during R1's transfer included the staff's failure to widen the lift legs and one staff did not stay with R1 while the other operated the lift. On 08/26/24 at 02:57 PM, CMA R stated on 08/13/24, she and CNA M used the Hoyer lift to transfer R1 into the shower chair but as soon as she turned the lift to place R1 in the shower chair from his bed, one of the straps came off and as he fell , another loop came off. She stated it was R1's left side loops that came off. She stated R1 fell on to the floor and his back hit the lift leg. She stated CNA M tried moving the lift out of the way while she got the nurse. CMA R stated they did not use the last loop during Hoyer lift transfer because it did not lift the resident high enough. She stated R1 complained of his back hurting really badly and that he voiced being scared. CMA R stated she completed lift competencies after the incident. On 08/26/24 at 03:03 PM, CNA M stated on 08/13/24, she and CMA R got R1 ready to transfer to the shower chair. She stated they hooked up R1's lift sling to the Hoyer lift and made sure the loops were hooked up correctly. CNA M stated as soon as they lifted R1 and turned the lift toward the shower chair, they thought the lift strap broke. She stated it was his left side that came off, so she assumed his shift in weight caused it because of his left leg amputation. CNA M stated after the incident, Administrative Nurse D pulled her, and the other staff involved in the incident from the floor and went over what happened and did education on how to run the lift properly. She stated during the re-enactment, the Regional Consultant told her they did not open the legs of the lift when moving it and told them the legs needed to be opened for stability. CNA M stated she received lift competencies after the incident. The facility's Safe Resident Handling/Transfers policy, dated 2023, directed all residents required safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. The policy directed two staff members utilized a mechanical lift and staff received education on the use of safe handling/transfer practices to include the use of mechanical lifts upon hire and as the need arose. The facility failed to ensure R1 remained free from preventable accidents during a Hoyer lift transfer. This deficient practice resulted in impaired psychosocial well-being and placed R1 at risk for further complications. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility put the following corrections into place: The facility updated R1's care plan on 08/13/24. Maintenance U inspected the Hoyer lift on 08/13/24. Physical Therapy (PT) evaluated R1 on 08/14/24. Direct care staff received mechanical lift, fall prevention, and abuse education on 08/14/24. Because the facility implemented and completed the corrections prior to the onsite survey, this deficient practice was cited as past noncompliance.

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47834 The facility identified a census of 23 residents. The sample included nine residents. Based on observation, record review, and interview, the facility failed to provide appropriate treatment and care for Resident (R) 2's peripherally inserted central catheter (PICC-a thin, flexible tube that is inserted into a vein in the upper arm and threaded into a large vein above the heart) including monitoring the resident's status for complications and providing a sterile dressing change per the standards of care for a PICC line at least every seven days. R2 admitted to the facility on [DATE] with a PICC line in place for administration of intravenous (IV - administered directly into the bloodstream via a vein) antibiotics. R2's clinical record lacked evidence that the staff had changed R2's PICC dressing while he was in the facility. On 08/19/24 R2 went to the acute care hospital for possible sepsis (a threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body). The hospital staff identified R2's PICC dressing was 38 days old. The staff's failure to provide ongoing monitoring of the dressing status, the failure to identify the lack of dressing orders as well as failure to provide a sterile dressing change for over five weeks placed R2 in immediate jeopardy. Findings included: - R2's Electronic Medical Record (EMR) documented a diagnosis of cerebral infarction (stroke - 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), pressure-induced deep tissue damage (pressure ulcer - localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of the sacral region (sacrum - large triangular bone/area between the two hip bones), open wound of lower back and pelvis, weakness, systolic congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). The Admission Minimum Data Set (MDS), dated [DATE], for R2 noted the Brief Interview for Mental Status (BIMS) assessment was unable to be completed. The MDS documented R2 had problems with short-term and long-term memory. The MDS further documented R2 had poor decision-making and required cues and supervision. The MDS documented R2 used a wheelchair and required substantial, maximal assistance for transition from lying to a seated position on the edge of a bed, sitting to stand, bathing, toileting hygiene, lower body dressing, and transfers. The MDS documented R2 was on antibiotics and had one stage four (a deep pressure wound that reaches the muscles, ligaments, or even bone) pressure ulcer. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 07/18/24, documented R2 had obvious long- and short-term memory deficits. The CAA documented R2 was admitted to the facility following a hospital stay secondary to a sacral wound with infection and was on IV antibiotics. The CAA further documented R2 required assistance with ADL completion and had a wound vacuum-assisted closure device (wound vac - a wound healing therapy that uses negative pressure to help wounds heal) in place to his sacral area. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's Care Plan, with an initiated date of 07/23/24, documented R2 had an infection of his sacral wound. An intervention with an initiated date of 07/23/24, directed staff to administer IV medication through PICC as ordered and to flush the PICC line with 10 cubic centimeters (cc) of normal saline (NS - saline water solution for medical use) before and after use. R2's Care Plan lacked evidence of any further documentation related to R2's PICC line. R2's Care Plan lacked evidence of dressing changes related to his PICC line. R2's EMR recorded the following orders: A Physician's Order dated 07/12/24 directed staff to flush PICC with 10 cc of NS before and after administering the antibiotic. The order was discontinued on 08/05/24. A Physicians Order dated 07/12/24 for ceftriaxone two grams IV for wound infection. The order was discontinued on 08/05/24. A Physician's Order dated 08/05/24 directed staff to flush PICC with 10 cc or NS twice daily until removed. The order was placed on hold on 08/19/24. R2's EMR lacked evidence of an order to change R2's PICC line dressing. An Admission Note dated 07/12/24, documented R2 was oriented to his room and the facility. The note further documented R2 had a wound vac placed and medications ordered to start IV antibiotics in the morning. A Nurse Note dated 07/14/24 at 12:05 PM recorded R2 continued with IV antibiotics. R2 had a PICC line, the site was patent and flowing without concerns. There was no redness, edema or irritation noted. R2's dressing remained intact. R2's EMR lacked another PICC site assessment until 07/17/24. A Skilled Note dated 07/15/24 at 02:41 PM noted R2 continued with IV antibiotics per PICC line. R2 had a ground diet with thickened liquids and was dependent on staff to heat [sic]. R2's wound vac continued. A Skilled Note dated 07/16/24 at 02:45 PM noted R2 continued with the same diet and was adjusting to the environment. R2 received IV antibiotics per a PICC line. An Infection Note dated 07/17/24 at 10:30 AM noted R2 remained on IV antibiotics with no adverse reactions. The PICC line was patent and flowing. There was no redness or swelling to the insertion site. R2 remained afebrile (without fever). An Infection Note dated 07/18/24 at 03:59 AM noted R2 continued IV antibiotics with no adverse reactions. The PICC line was patent and flowing. There was no redness or swelling to the insertion site. R2 remained afebrile (without fever) and had no adverse reactions to the medications. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nurse Note dated 07/19/24 at 02:47 PM noted staff attempted to flush both ports of the PICC line and was met with great resistance in both ports. Staff notified Consultant HH. Staff attempted to start a peripheral IV two times. The first attempt infiltrated after piercing the vein. The second attempt was not able to get into the vein. Staff applied pressure at the site of both insertion attempts until R2 was no longer bleeding, and then applied a dressing. Staff notified Consultant HH to inform him they were not successful in placing a peripheral IV. Staff awaited a return call. An Orders Administration Note dated 07/19/24 at 04:07 PM noted for the flush order, staff could not flush the PICC line due to stagnant blood in the line. Staff notified the physician and Administrative Nurse D. R2's EMR lacked notation of any follow up or treatments regarding this situation. An Orders Administration Note dated 07/20/24 at 09:32 AM noted IV ceftriaxone (antibiotic) two grams was administered. The PICC line was patent and flowing with no redness or edema at the site. R2's EMR lacked evidence of another PICC site assessment until 07/26/24. A Skilled Note dated 07/25/24 at 06:52 PM noted R2 was very cooperative and pleasant. He followed directions and assisted staff at times. He spent time with physical therapy (PT) and occupational therapy (OT) for therapies. He was only able to tolerate sitting up for short periods of time and asked to lie down in bed. He had a wound vac in place to the sacrum and a central line that was flushed daily with antibiotic infusion. A Skilled Note dated 07/26/24 at 03:25 AM noted R2 had a wound vac in place to the sacrum and a central line that was flushed daily with antibiotic infusion. R2 slept well throughout the night. A Skilled Note dated 07/26/24 at 07:17 PM noted R2 had a central line in the left upper arm. The IV line was flushed before and after antibiotics were infused. The IV site remained without redness, swelling, or pain and flushed easily. He also had a wound vac to the sacral area that was changed three times weekly and as needed. He had a Foley catheter (a tube inserted into the bladder to drain urine) that was draining brownish urine. He was on a fluid restriction, but he did not drink fluids and took much encouragement. He was repositioned in his bed and was encouraged to sit up in the chair for short periods as tolerated. A Skilled Note on 07/27/24 at 05:24 AM noted R2 had a wound vac in place to the sacrum and a central line that was flushed daily with antibiotic infusion. R2 slept well throughout the night. An Orders Administration Note dated 07/27/24 at 08:17 AM noted IV ceftriaxone two grams was administered. The PICC line was patent and flowing with no redness or edema at the site. An Orders Administration Note dated 07/28/24 at 08:48 AM noted IV ceftriaxone two grams was administered. The PICC line was patent and flowing with no redness or edema at the site. An Infection Note dated 07/28/24 at 11:11 AM noted R2 continued IV antibiotic for a wound infection with no signs or symptoms of adverse reactions. R2 was afebrile. The IV site was patent and intact, and no other concerns were noted. R2's EMR lacked evidence the PICC site was assessed again until 07/30/24. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Infection Note dated 07/30/24 at 02:30 PM noted R2 remained on IV antibiotic with no adverse reactions noted. There was no redness or swelling noted to the IV site. R2 was afebrile. R2's EMR lacked evidence the PICC site was assessed again until 08/03/24. An Infection Note dated 07/31/24 at 11:49 AM noted R2 continued taking IV antibiotic medication for the treatment of a wound infection. R2 had no adverse reactions and was afebrile. An Infection Note dated 07/31/24 at 04:01 AM noted R2 continued taking antibiotic medication via IV for the treatment of a wound infection. R2 had a wound vac in place on his sacrum wound. R2 had no adverse reactions to the medication. An Infection Note dated 08/01/24 at 03:11 AM noted R2 remained on IV antibiotics for the treatment of a wound infection. R2 had a wound vac in place on his sacrum. R2 did not have any adverse reactions to his medication. A Nursing Quarterly Evaluation Note dated 08/02/24 at 04:51 AM documented a review of systems but made no mention of the PICC line. An Infection Note dated 08/02/24 at 05:34 AM noted R2 remained on IV antibiotics for the treatment of a wound infection. R2 had a wound vac in place on his sacrum. R2 did not have any adverse reactions to his medication. A Skilled Note dated 08/02/24 at 02:45 PM noted R2 was up in his wheelchair for lunch and tolerated it well. R2 was dependent in eating his meals. He just looked at his food and did not try to eat. R2 stated, I have trouble swallowing some foods and I need it soft. R2 had a central IV line for the administration of antibiotics daily. He had a wound vac to the sacrum for a Stage 4 pressure ulcer which was present on admission. An Infection Note dated 08/03/24 at 08:07 AM noted R2 remained on IV antibiotics treatment for a wound. R2 did not have any adverse reactions at that time. R2's IV was patent and flowing slowly. There was no redness or edema to the PICC line site. An Orders Administration Note dated 08/03/24 at 08:13 AM noted IV ceftriaxone two grams was administered. The PICC line was patent and flowing with no redness or edema at the site. An Infection Note dated 08/04/24 at 09:47 AM noted R2 remained on IV antibiotics treatment for a wound. R2 did not have any adverse reactions at that time. R2's IV was patent and flowing slowly. There was no redness or edema to the PICC line site, and no other concerns were noted. R2's lacked evidence the PICC site was assessed again until 08/08/24. An Infection Note dated 08/05/24 at 03:41 AM noted R2 remained on IV antibiotics for the treatment of a wound infection. R2 had a wound vac in place on his sacrum. R2 did not have any adverse reactions to his medication. A Nurse Note dated 08/05/24 at 09:58 AM noted staff called Consultant HH regarding the order to discontinue R2's Rocephin (ceftriaxone) and asked whether to leave the PICC line in or remove it. Staff awaited a return call. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nurse Note dated 08/05/24 at 01:33 PM noted staff received a call back from Consultant HH's office with orders to leave the PICC line in and flush twice daily. Staff were directed to call back in 48 hours and ask Consultant HH at that point whether to remove the PICC or keep it in. R2's EMR lacked evidence this follow-up call was placed. A Nurse Note dated 08/08/24 at 05:25 PM noted R2 had a central line to the left upper arm. One port flushed easily but the other port always had trouble flushing since he was admitted . The central line site was without erythema (redness), drainage, or swelling at that time. A Nurse Note dated 08/08/24 at 07:15 PM noted the PICC flush was not done due to the nurse was not IV certified. A Nurse Note dated 08/12/24 at 12:59 PM noted R2's representative was concerned that R2 was dehydrated and asked for IV fluids. Staff called Consultant HH's office with the request. A Nurse Note dated 08/12/24 at 02:45 PM noted staff received a return call from Consultant HH's office with orders for 250 cc of NS over three hours one time only to be administered the following day when it arrived from the pharmacy. R2's August 2024 Medication Administration Record /Treatment Administration Record (MAR/TAR) lacked evidence the 250 cc NS was administered on 08/13/24 as initially ordered. The MAR/TAR recorded R2 received the 250 cc NS on 08/14/24 at 09:55 AM. R2's August 2024 MAR/TAR lacked evidence the PICC flush was administered in the evening of 08/15/24 and the morning of 08/16/24. An Order Note dated 08/19/24, documented R2 had a decline in alertness, his blood pressure had decreased, and his pulse increased from his normal range. The note documented R2 refused to eat or drink much and his wound to the coccyx was black in color with a strong foul smell. Staff placed a call to the provider and an order was received to send R2 to the emergency room . A Nurse Note dated 08/19/24 documented an ambulance arrived at the facility and transported R2 to the emergency room at 01:10 PM. R2's Emergency Department Note dated 08/19/24 recorded R2 had an old PICC line with a dressing dated 07/13/24 still in place in R2's left upper arm. R2's clinical record from 07/12/24 through the survey date 08/26/24 lacked evidence a PICC dressing was completed. On 08/21/24 at 04:23 PM, Hospital Nurse II stated R2 was admitted for sepsis. Hospital Nurse II stated when R2 arrived at the hospital, the nursing staff identified improper PICC line care since the dressing had not been changed since 07/13/24. Hospital Nurse II went on to say that failing to change the dressing could have contributed to R2's sepsis but it was hard to say for sure since R2's sacral wound was also in very bad condition when he arrived. Hospital Nurse II stated R2's wound was really bad and showed signs of neglect. Hospital Nurse II confirmed R2 had transferred to another hospital for a higher level of care. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/22/24 at 11:25 AM Licensed Nurse (LN) H stated she had not received any education related to PICC line care or dressing changes at the facility. LN H stated she had prior emergency room experience and knew how to take care of a PICC line; however, she further stated she had not received any competency check-off to ensure she knew how to care for a PICC line at the facility prior to caring for a resident that had a PICC line. LN H stated this is a skilled facility and we need to have the skills and training. LN H stated in the hospital setting she would change a PICC line dressing once a week but was not sure about the guidelines in the long-term care setting. She stated staff were flushing R2's PICC line twice daily. LN H stated if a PICC line dressing had been done for R2, it would have been documented on the MAR, and TAR, and all dressing changes would have been documented in that location. LN H stated staff had missed putting in orders sometimes, but if she noticed a dressing needed changed, then she would change it, or if there were no orders she would contact the provider, obtain an order, and then change the dressing. LN H further stated if she noticed a PICC line dressing had a last changed date that was over a week old she would check the order, contact the provider to obtain an order if there was not one, and change the dressing. LN H stated she was unsure what order R2 had related to his PICC line dressing. She stated she had questioned it but was not sure if anything came of it. LN H stated even if staff were monitoring and assessing the site, that would not be enough, and the dressing would need to be changed. LN H stated if PICC line dressings are not changed, then the resident would have an increased risk of infection, and she further stated the risk to the resident would be greater due to the PICC being a central line. On 08/22/24 at 11:44 AM Administrative Nurse D stated the facility had just completed a skills fair for the staff on 07/20/24 to 07/21/24 and the facility included central line education during the skills fair. Administrative Nurse D stated all staff were required to attend. Administrative Nurse D stated she was unsure if the staff had received PICC line care education prior to their recent skills fair and there were no skills checks done to verify staff knew how to care for a PICC line prior to staff providing care. Administrative Nurse D stated she had asked a few of their nurses, and they reported to her that they had not received the education at the facility previously. Administrative Nurse D stated the training should have been done once per year. Administrative Nurse D stated PICC line dressings would have been changed once per week and documented in the MAR and TAR when it was completed, and the new dressing should have been dated when it was changed. Administrative Nurse D stated if staff noted a PICC line dressing had a last changed date that was a week or more old, the expectation was for staff to change the dressing and that it was policy. Administrative Nurse D stated that even if there was no order for the dressing change, it would still need to have been changed. Administrative Nurse D stated doctors do not typically order PICC line dressing changes; however, staff are still able to place an entry in the resident's EMR that would have notified staff to change the dressing that they could have charted against. Administrative Nurse D stated if a PICC line dressing was not changed for over a week or more, the resident would have been at an increased risk of infection. Administrative Nurse D further stated staff would not have been able to fully assess the insertion site if they were not changing the dressings each week. A policy related to PICC line care was not provided by the facility. On 08/22/24 at 02:16 PM, the facility received the Immediate Jeopardy [IJ] Template and was informed that the facility's failure to provide appropriate treatment and care for R2's PICC including monitoring the resident's status for complications and providing a sterile dressing change per the standards of care, placed R2 in immediate jeopardy. On 08/22/24 at 06:05 PM, the facility provided an acceptable plan for removal of the immediacy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175323	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare	412 E Walnut St Nortonville, KS 66060

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 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/26/24 the facility completed corrective actions which included halting admission immediately of any resident who would require a PICC line or other IV as part of their care. No individuals with a PICC line or other type of IV will be admitted to the facility until re-education with all current licensed has been completed, and return competency demonstrated. Responsibility for the education of the staff was assigned to the Director of Nursing (DON) and/or designee. The Regional Consultant nurse ensured the competency of the DON prior to educating staff. Competency and education were provided to IV-certified RNs and LPNs by DON and/or designee. There were no residents in the facility with a PICC line or other type of IV as of 08/26/24. The surveyor verified the implementation of the corrective actions and removal of the immediacy onsite on 08/26/24 at 02:00 PM. The deficient practice remained at a scope and severity of D.