STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175373	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Burlington	601 Cross Street Burlington, KS 66839

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 74 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to ensure all residents remained free from abuse when Resident (R)17 stomped on R8's foot after R8, who was cognitively impaired, went into R17's room. This placed the residents at risk for injury and ongoing abuse. Findings included: - The Electronic Medical Record (EMR) for R17 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), hypertension (high blood pressure), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Significant Change Minimum Data Set (MDS), dated [DATE], documented R17 had intact cognition and was dependent upon staff for toileting, lower body dressing, and transfers. R17 required substantial assistance for bathing, and mobility, and did not ambulate. R17 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and antidepressant (a class of medications used to treat mood disorders) medication. R17's Care Plan, dated 11/21/24 and initiated on 08/11/22, documented R17 had a history of behaviors and directed staff to intervene as necessary to protect the rights and safety of others, approach and speak calmly, divert attention, remove from the situation, and administer medications as needed. The care plan further directed staff to observe for behavior episodes and attempt to determine the underlying causes. The update, dated 04/20/24, documented R17 had the potential to be physically aggressive related to anger, dementia, a history of harm to others, and poor impulse control. The care plan directed staff to de-escalate her behaviors by talking, listening, and directing her to a quieter area. R17's Nurse's Note, dated 08/13/24 at 04:41 AM, documented that R17 went to the nurse's desk and told her that she stomped on another resident's foot several times when they entered her room. The note further documented that staff educated R17 not to do that. A review of R8's EMR revealed a Nurse's Note, dated 08/13/24 at 04:43 AM that documented R8 had her foot stomped on by another resident. Staff assessed R8 who had no complaints of pain or any other discomfort. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 08:21 AM, observation revealed R17 sat at the dining table and joked about staff apparel. On 12/10/24 at 03:30 PM, Consultant GG stated she did not have an incident report when R17 stomped on R8's foot, but she would start an investigation and report the incident to the State Agency. On 12/11/24 at 11:06 AM, Certified Nurse Aide (CNA) M stated R17 had behaviors and liked to pick on the other residents to get them upset. CNA M stated she was unaware of any resident-to-resident altercations but said she would notify the nurse if she ever saw any. On 12/11/24 at 11:19 AM, Administrative Nurse E stated that staff were to notify the charge nurse of any resident-to-resident altercations, and an investigation would be started. Administrative Nurse E further stated staff will make sure the two residents are separated and kept safe. On 12/11/24 at 12:30 PM, Administrative Nurse D stated the incident should have been reported so an investigation could be completed, and interventions put into place. The facility's Abuse - Identification of Types policy, dated 06/17/24, documented the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The risk for abuse may increase when a resident exhibits behavior that may provoke a reaction by staff, residents, or others, such as hitting, kicking, shoving, biting, spitting, threatening gestures, throwing objects, touching or grabbing, and wandering into others rooms or spaces. The facility failed to prevent resident-to-resident abuse when R17 stomped on R8's foot several times. This placed the residents at risk for injury and ongoing abuse.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 74 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to identify a resident-to-resident incident as abuse and report immediately to the administrator when Resident (R)17 stomped on R8's foot after R8, who was cognitively impaired, went into R17's room. This placed the residents at risk for unidentified and ongoing abuse. Findings included: - The Electronic Medical Record (EMR) for R17 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), hypertension (high blood pressure), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Significant Change Minimum Data Set (MDS), dated [DATE], documented R17 had intact cognition and was dependent upon staff for toileting, lower body dressing, and transfers. R17 required substantial assistance for bathing, and mobility, and did not ambulate. R17 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and antidepressant (a class of medications used to treat mood disorders) medication. R17's Care Plan, dated 11/21/24 and initiated on 08/11/22, documented R17 had a history of behaviors and directed staff to intervene as necessary to protect the rights and safety of others, approach and speak calmly, divert attention, remove from the situation, and administer medications as needed. The care plan further directed staff to observe for behavior episodes and attempt to determine the underlying causes. The update, dated 04/20/24, documented R17 had the potential to be physically aggressive related to anger, dementia, a history of harm to others, and poor impulse control. The care plan directed staff to de-escalate her behaviors by talking, listening, and directing her to a quieter area. R17's Nurse's Note, dated 08/13/24 at 04:41 AM, documented that R17 went to the nurse's desk and told her that she stomped on another resident's foot several times when they entered her room. The note further documented that staff educated R17 not to do that. A review of R8's EMR revealed a Nurse's Note, dated 08/13/24 at 04:43 AM that documented R8 had her foot stomped on by another resident. Staff assessed R8 who had no complaints of pain or any other discomfort. On 12/10/24 at 08:21 AM, observation revealed R17 sat at the dining table and joked about staff apparel. On 12/10/24 at 03:30 PM, Consultant GG stated she did not have an incident report when R17 stomped on R8's foot, but she would start an investigation and report the incident to the State Agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 11:06 AM, Certified Nurse Aide (CNA) M stated R17 had behaviors and liked to pick on the other residents to get them upset. CNA M stated she was unaware of any resident-to-resident altercations but said she would notify the nurse if she ever saw any. On 12/11/24 at 11:19 AM, Administrative Nurse E stated that staff were to notify the charge nurse of any resident-to-resident altercations, and an investigation would be started. Administrative Nurse E further stated staff will make sure the two residents are separated and kept safe. On 12/11/24 at 12:30 PM, Administrative Nurse D stated the incident should have been reported so an investigation could be completed, and interventions put into place. The facility's Abuse - Conducting an Investigation policy, dated 06/17/24, documented when an incident or suspected incident of resident abuse, and/or neglect, injury of unknown source, exploitation, or misappropriation of resident property, staff would respond immediately to protect the alleged victim, and report to administration or designee for an investigation to occur. The facility failed to identify a resident-to-resident incident as abuse and report immediately to the administrator when R17 stomped on R8's foot after R8 went into R17's room. This placed the residents at risk for unidentified and ongoing abuse.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 74 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to provide protective measures and investigate an incident of resident-to-resident abuse by Resident (R)17, who stomped on R8's foot after R8, who was cognitively impaired, went into R17's room. This placed the residents at risk for unidentified and ongoing abuse. Findings included: - The Electronic Medical Record (EMR) for R17 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), hypertension (high blood pressure), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Significant Change Minimum Data Set (MDS), dated [DATE], documented R17 had intact cognition and was dependent upon staff for toileting, lower body dressing, and transfers. R17 required substantial assistance for bathing, and mobility, and did not ambulate. R17 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and antidepressant (a class of medications used to treat mood disorders) medication. R17's Care Plan, dated 11/21/24 and initiated on 08/11/22, documented R17 had a history of behaviors and directed staff to intervene as necessary to protect the rights and safety of others, approach and speak calmly, divert attention, remove from the situation, and administer medications as needed. The care plan further directed staff to observe for behavior episodes and attempt to determine the underlying causes. The update, dated 04/20/24, documented R17 had the potential to be physically aggressive related to anger, dementia, a history of harm to others, and poor impulse control. The care plan directed staff to de-escalate her behaviors by talking, listening, and directing her to a quieter area. R17's Nurse's Note, dated 08/13/24 at 04:41 AM, documented that R17 went to the nurse's desk and told her that she stomped on another resident's foot several times when they entered her room. The note further documented that staff educated R17 not to do that. A review of R8's EMR revealed a Nurse's Note, dated 08/13/24 at 04:43 AM that documented R8 had her foot stomped on by another resident. Staff assessed R8 who had no complaints of pain or any other discomfort. On 12/10/24 at 08:21 AM, observation revealed R17 sat at the dining table and joked about staff apparel. On 12/10/24 at 03:30 PM, Consultant GG stated she did not have an incident report when R17 stomped on R8's foot, but she would start an investigation and report the incident to the State Agency. On 12/11/24 at 11:06 AM, Certified Nurse Aide (CNA) M stated R17 had behaviors and liked to pick on the other residents to get them upset. CNA M stated she was unaware of any resident-to-resident altercations but said she would notify the nurse if she ever saw any. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 11:19 AM, Administrative Nurse E stated that staff were to notify the charge nurse of any resident-to-resident altercations, and an investigation would be started. Administrative Nurse E further stated staff will make sure the two residents are separated and kept safe. On 12/11/24 at 12:30 PM, Administrative Nurse D stated the incident should have been reported so an investigation could be completed, and interventions put into place. The facility's Abuse-Conducting an Investigation policy, dated 06/17/24, documented that any allegation of abuse was promptly and thoroughly investigated. The facility would prevent further abuse, neglect, exploitation, and mistreatment from occurring while the investigation was in progress and take corrective action. Residents have the right to live at ease in a safe environment without the fear of retaliation when allegations are reported. Staff would report and respond immediately to protect the alleged victim and an investigation would be conducted as appropriate. The facility failed to provide protective measures and investigate an incident of resident-to-resident abuse by R17, who stomped on R8's foot after R8 went into R17's room. This placed the residents at risk for injury and ongoing abuse.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 74 residents. The sample included 18 residents with three reviewed for hospitalization . Based on observation, interview, and record review the facility failed to provide written notification for the facility-initiated transfers and further failed to notify the Office of the Long-Term Care Ombudsman (LTCO-a public official who works to resolve resident issues in nursing facilities) when Residents (R) 42, R32, and R217 discharged to a hospital. This placed the resident at risk for uninformed care decisions and impaired resident rights. Findings included: - R42's Electronic Medical Record (EMR) documented diagnoses of fracture of shaft of right fibula (a break in the middle section of the right lower outer leg bone), displaced fracture of right tibia (a broken bone in the inner part of the ankle that has moved out of place), displaced dome fracture of right talus (the top surface of the talus bone (the dome) has fractured and moved out of its normal position). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 11. The MDS documented R42 was dependent on staff assistance for most activities of daily living, including mobility, and used a wheelchair. The MDS documented R42 had shortness of breath and almost constant severe pain. R42 had a fall with fractures and orthopedic (bone) surgery since the prior MDS assessment. R42's Care Plan dated 11/21/24 documented R42 was at risk for falls and directed staff to anticipate and meet her needs, ensure her call light was within reach, and respond promptly to all requests for assistance, initiated 11/10/24. The plan directed staff to observe for, and report signs and symptoms of hip fracture complications, initiated 11/10/24. The plan documented that Physical Therapy (PT) and Occupational Therapy (OT) were to evaluate and treat per orders, initiated 11/10/24. The Progress Note, dated 10/29/24 at 12:34 AM, documented that staff assisted R42 to the bathroom when her legs gave out and she was lowered to the floor. R42 went to her knees, bent her right leg, and heard a pop. She reported severe pain and requested to go to the emergency room . The Progress Note, dated 10/29/24 at 02:39 AM, documented R42 was sent to the emergency room by ambulance at approximately 12:15 AM. The Progress Note, dated 10/29/24 at 11:54 PM, documented R42 was pale, sweaty, had a bounding pulse, and was in and out of consciousness. Staff called 911 and transferred R42 to the emergency room . R42 was admitted to a hospital ICU (Intensive Care Unit). A review of R42's clinical record lacked evidence the resident or representative was provided written notice of transfer/discharge when R42 was transferred to the hospital. The facility was unable to provide evidence of written notification of the transfers or notification to the LTCO. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/24 at 09:10 AM, observation revealed R42 lay in bed with her call light in reach. She stated she got up to go to the bathroom, fell , and sustained fractures in November. On 12/10/24 at 10:38 AM, Social Services Staff X stated the facility did not notify the LTCO when a resident was not discharged but instead was placed on medical leave with Medicaid payment for the bed hold. She verified the facility had not given the resident written notice of the discharge or transfer to the hospital and had not sent the notice to the LTCO. The facility's Notice of Transfers and Discharges policy, dated 10/29/24, stated the facility would provide written notification including the following: The reason for the transfer or discharge and the location to which the resident is transferred or discharged . A copy of the notice of transfer or discharge will be sent to a representative of the Office of the State Long-Term Care Ombudsman for all facility-initiated transfers or discharges. The facility failed to provide written notification for R42's facility-initiated transfer and further failed to notify the LTCO of the transfer, placing R42 at risk for uninformed care decisions and impaired resident rights. 32358 - R32's Electronic Medical Record (EMR) documented R32 had a diagnosis of emphysema (long-term, progressive disease of the lungs characterized by shortness of breath), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), acute (a condition characterized by a relatively sudden onset of symptoms that are usually severe) respiratory failure (a serious condition that occurs when the lungs can't get enough oxygen into the blood or remove enough carbon dioxide from the body), and bradycardia (low heart rate, less than 60 beats per minute). R32's Modified Quarterly Minimum Data Set (MDS), dated [DATE], documented R32 had a Brief Interview of Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS documented the resident had COPD, respiratory failure, and heart failure. R32's Care Plan, revised 10/02/24, documented that R32 had heart failure, bradycardia, and COPD and instructed staff to encourage R32 to call for assistance if chest pain started. Staff were directed to observe R32 and report as needed (PRN) any changes in lung sounds, edema (swelling), shortness of breath, and weight change to the physician. The Progress Notes, dated 08/03/24 at 11:40 AM documented the nurse went in to assess R32's oxygen levels and R32's oxygen saturation was 69% (normal oxygen level is between 95% and 100%). The nurse changed R32's nasal cannula (a medical device that provides supplemental oxygen to a patient through two prongs that fit into the nostrils) to a face mask (a device worn over the nose and mouth to supply oxygen to a patient). R32 was sent to the hospital and admitted . The Progress Notes, dated 09/13/2024 at 04:14 PM documented R32 was very short of breath. R32 received an as-needed (PRN) Lasix (diuretic medication) at 11:30 AM and a breathing treatment at noon though neither intervention had any effect on R32's ease of breathing. The note documented R32 was sent to the hospital and admitted . (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R32's clinical record lacked evidence the resident or representative was provided written notice of transfer/discharge when she was transferred to the hospital. The facility was unable to provide evidence of written notification of the transfers or notification to the LTCO. On 12/09/24 at 03:44 PM, observation revealed R32 sat in a wheelchair at a dining room table and participated in a bingo activity. On 12/11/24 at 09:18 AM, Social Service X verified the facility had not provided written notification of transfer to R32 or her representative or the LTCO when R32 was transferred to the hospital on the above dates. Social Services X stated she was unaware she was supposed to. On 12/12/24 at 12:28 PM, Administrative Nurse D stated he was unsure who was responsible for providing written notice to the resident or her representative about the reason for her transfer to the hospital or for notifying the ombudsman. Administrative Nurse D said he thought it was Social Service X's duty. The facility's Ombudsman Program Policy, revised 09/26/24, documented that before a facility transfers or discharges a resident the facility must notify the resident and representative of the transfer or discharge and the reason for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the LTCO office. The facility failed to provide written notice to R32 or her representative and failed to notify the LTCO regarding R32's facility-initiated transfers to the hospital. This placed the resident at risk of uninformed care choices and impaired resident rights. 32360 - The Electronic Medical Record (EMR) for R217 documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), psychosis (any major mental disorder characterized by a gross impairment in reality perception), impulse disorder (sudden, forceful, irresistible urges to do something anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The Admission Minimum Data Set (MDS), dated [DATE], documented R217 had severely impaired cognition and required set-up assistance for eating, toileting, bathing, dressing, and personal hygiene. R217 was independent with mobility, transfers, and ambulation. R217 had inattention, disorganized thinking, delusions, and verbal behaviors one to three days of the observation period, and significantly disrupted his care and the environment. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R217's Care Plan, dated 10/24/24, documented R217 was at risk for elopement, and directed staff to encourage R217 to participate in activities to divert the resident from exit-seeking behavior. Staff were directed to provide frequent monitoring and provide for safe wandering. The update, dated 11/06/24, directed staff to give the resident choices about care and activities. When the resident became agitated, staff were to intervene before the agitation escalated, guide away from the source of distress, and engage calmly in conversation. If R217's response was aggressive, staff were to calmly walk away and approach later. The plan directed to obtain a psychiatric/psychogeriatric consult as indicated, and administer medications as ordered. The Nurse's Note, dated 11/15/24 at 02:13 PM, documented R217 was admitted to an acute behavioral unit. R217's EMR lacked documentation staff notified the LTCO of the resident's discharge from the facility. On 12/11/24 at 09:17 AM, Social Service X stated she had not notified the LTCO about the hospitalization and did not know she was supposed to do so for hospitalization transfers. On 12/11/24 at 12:30 PM, Administrative Staff A stated Social Service X did send a notification to the LTCO regarding discharged residents but was fairly new and didn't know that all discharged residents were to be sent. The facility's Notice of Transfers and Discharges policy, dated 10/29/24, documented the facility would send a copy of the transfer/discharge to a representative of the LTCO for all facility-initiated transfers or discharges. The facility failed to notify the LTCO of R217's facility-initiated discharge to an acute behavioral unit. This placed the resident at risk for impaired rights.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 74 residents. The sample included 18 residents, with two reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to ensure Resident (R) 47 received assistance eating her breakfast meal. This placed the resident at risk for choking, impaired nutrition, and further decline in ADL ability. Findings included: - The Electronic Medical Record (EMR) for R47 had diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), dysphagia (swallowing difficulty), and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R47 had severely impaired cognition, and required substantial assistance with all ADLs except for eating, for which she required supervision. R47 had no weight loss or gain and received a mechanically altered diet. R47's Care Plan, dated 11/26/24, initiated on 08/01/23, directed staff to provide supervision and touching assistance at meals. The update, dated 05/31/24, directed staff to encourage the resident's socialization and interaction with tablemates during meals, observe and report any dysphagia, and provide and serve diet as ordered. The update, dated 11/26/24, directed staff to provide appropriate finger foods when available to encourage intake. On 12/10/24 at 09:05 AM, observation in the memory care unit revealed two certified nurse aides (CNAs) getting residents to the dining tables for breakfast. Administrative Nurse E talked to Licensed Nurse (LN) H while a dietary staff member and Administrative Staff A passed meal trays. Further observation revealed at 09:10 AM, R47 and R9 sat at a dining room table waiting for breakfast. At 09:14 AM, R47 was provided biscuits and gravy, eggs, and oatmeal. Further observation revealed R9, a cognitively impaired resident, began to feed R47 small bites of her meal. R9 also held up R47's cup to provide her with a drink. Continued observation revealed R9 continued to assist R47 until 09:30 AM when Administrative Staff E, who was assisting another resident at a table across the room, saw R9 assisting R47 and told LN H to tell R9 not to assist R47 with breakfast. LN H went to the table and told R9 that R47 was able to feed herself and told R9 not to assist R47. LN H did not offer assistance to R47. On 12/10/24 at 09:58 AM, observation revealed R47 had her bowl of oatmeal in her left hand and used her right hand to scoop out a handful of oatmeal and proceeded to eat it. R47 continued to do this until she had eaten the whole bowl. R47's hands were dirty with oatmeal, and she reached for her baby doll and got oatmeal all over the doll. Continued observation revealed R47 had pieces of egg and oatmeal on her lap which she picked up and ate. R47 attempted to clean the food particles on her lap but appeared unsure what to do with them so she ate them or wiped them off her pants. R47 was not wearing a clothing protector. Observation revealed at 10:07 AM, Aadministrative Nurse E walked over to R47 and wiped her hands off with her napkin. (continued on next page)

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	175373	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Burlington	601 Cross Street Burlington, KS 66839

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 10:15 AM, LN H stated R47 was able to feed herself and should not receive assistance from other residents. LN H further stated if R47 was tired, staff would cue and encourage her as needed. On 12/11/24 at 11:15 AM, CNA M stated R47 was independent with meals unless she had a bad day and was over-tired, then staff would cue her. CNA M further stated that R9 was not supposed to assist another resident and that staff should have assisted R47. On 12/11/24 at 12:30 PM, Administrative Nurse D stated that residents were not to assist other residents with meals due to choking hazards. Administrative Nurse D said he had already provided education to the memory care staff on making sure staff assisted the residents as needed. The facility's Activities of Daily Living (ADLs) policy, documented that residents would receive assistance needed to complete ADLs, and any changes would be reported to the nurse. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. Any resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility failed to ensure staff provided R47 with the necessary ADL assistance with her breakfast meal. This placed the resident at risk for choking, impaired nutrition, and further decline in ADL ability.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 26768 The facility had a census of 74 residents. Based on observation, interview, and record review the facility failed to provide the services of a full-time certified dietary manager for 73 residents who resided in the facility and received their meals from the kitchen. This placed the residents at risk for inadequate nutrition. Findings included: - On 12/09/24 at 08:25 AM, observation in the facility's kitchen revealed staff preparing and serving breakfast. Dietary Staff (DS) BB assisted with serving the meals. On 12/09/24 at 08:30 AM, DS BB verified she was the Dietary Manager and stated she had not completed a state-approved dietary manager certification course or test. Upon request, the facility did not provide a policy regarding the Certified Dietary Manager. The facility failed to employ a full-time certified dietary manager to evaluate residents' nutritional concerns and oversee the ordering, preparing, and storage of food for 73 residents in the facility. This placed the residents at risk for inadequate nutrition.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 74 residents. The sample included 18 residents with one reviewed for hospice services. Based on observation, record review, and interview the facility failed to ensure collaboration between the hospice provider and the facility for Resident (R)45, regarding the plan of care and the services provided including visit frequency, medications, and medical equipment. This placed the resident at risk of impaired end-of-life care. Findings included: - R45's Electronic Medical Record (EMR) documented the resident had diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and (encephalopathy (a broad term for any brain disease that alters brain function or structure). R45's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R45 was independent with eating, oral hygiene, toileting hygiene, and personal hygiene. R45 required The MDS documented R45 received hospice services. R45's Care Plan, revised 10/15/24, documented the resident required extensive staff assistance with toileting use and transfers and limited staff assistance with personal hygiene. The care plan documented R45 received hospice services and instructed staff to expect weight loss, adjust the provision of activities of daily living (ADLs) to compensate for the resident's changing in abilities, encourage participation to the extent the resident wishes to participate, and assess residents coping strategies and respect the resident's wishes. The care plan instructed staff to administer medications as the physician ordered and notify the physician immediately if there was breakthrough pain. The care plan instructed staff to reposition R45 for comfort as needed (PRN), work cooperatively with the hospice team to provide the resident's spiritual emotional, intellectual, physical, and social needs, and work with nursing staff to provide maximum comfort for the resident. The care plan lacked a contact number for hospice; what supplies, equipment, and medications hospice would provide; when hospice staff would be in the building, and what care they would provide. The Physician Order, dated 07/17/24 at 12:10 PM, instructed staff to admit R45 to hospice service. On 12/11/24 at 12:28 PM, Administrative Nurse D verified that R45's Care Plan lacked information regarding the phone number when hospice staff would visit the facility, and what medications and supplies they would provide. The Hospice Service Agreement, signed by the hospice on 11/19/24 and the facility executive director on 12/05/24, documented the facility shall designate a member of an interdisciplinary group who is responsible for working with hospice to coordinate care provided by the facility staff and hospice staff to any hospice patient. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure collaboration between the hospice provider and the facility for R45. This placed the resident at risk of impaired end-of-life care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 32358 The facility had a census of 74 residents. The sample included 18 residents. Based on observation, record review, and interviews the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when staff failed to provide sanitary catheter (a tube inserted into the bladder to drain urine) care and failed to implement Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) for Resident (R)40. The facility failed to implement an adequate water management program to prevent and /or mitigate risks from waterborne pathogens. This placed the residents at risk of contracting an infection or communicable diseases. Findings included: - A review of the facility's TELS system (a web-based platform that helps with building operations, including maintenance, service requests, and asset management) dated 03/08/24 revealed staff were instructed to conduct required monthly Legionella (a serious type of lung infection caused by inhaling water droplets or mist contaminated with Legionella bacteria) meetings and upload documentation. The sheet lacked documentation of the test for Legionella or that water was flushed throughout the facility. The second sheet had a picture of an unlabeled device. A review of the hot water temperature checks logbook sheets on 11/07/24, 12/22/24 12/29/24, and 12/05/24 revealed documentation regarding hot water temperatures in random rooms but lacked documentation regarding whether a flush was conducted. On 12/10/24 at 09:45 AM, observation revealed Certified Nurse Aide (CNA) N and Licensed Nurse (LN) G placed gloves on but not gowns. CNA N unfastened R40's incontinence brief from the sides pulled it down in between the resident's legs, and provided perineal (private area) care to R40's front perineal area. Further observation revealed LN G assisted R40 to turn on his left side. CNA N tucked the incontinence brief underneath R40's buttocks, then removed and discarded her gloves, used hand sanitizer, applied new gloves, applied barrier cream to the resident's back perineal area, removed and discarded her gloves, and applied new gloves. Further observation revealed CNA N assisted the resident in turning on his right side. LN G removed the incontinence brief and discarded it in the trash, then LN G removed and discarded her gloves and applied new gloves while CNA N fastened the resident's brief. Both staff placed the uncovered catheter bag into the resident's left leg of his gray jogging pants and then placed the right leg into the gray pants. Both staff assisted the resident in turning from side to side to pull up his gray pants. Continued observation revealed LN G placed the uncovered catheter bag on the left side of the bed with the bag touching the floor. CNA N raised the bed which brought the uncovered catheter bag off the floor. Both staff removed and discarded their gloves. CNA N washed her hands, while LN G tied up the trash bag and took it to the dirty utility room where she washed her hands. On 12/10/24 at 09:55 AM, CNA N, and LN G both stated that staff were supposed to use EBP and verified they should have donned a gown before providing catheter care for R40. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/10/24 at 01:30 PM, Maintenance Staff (MS) V and Administrative Staff A stated the TELS system in the computer popped up monthly when the maintenance needed to conduct a Legionella test. MS V stated he checked the hot water temperature weekly in 15-20 rooms and conducted a water flush in the toilet of each room. MS V verified he had not documented the flushes. Administrative Staff A stated the facility had no designated Water Management Plan. Administrative Staff A stated if the community would have an outbreak of Legionella in their water system, they would test the facility water or whenever it indicated for maintenance check on the facility TELS system in the computer. On 12/11/24 at 11:19 AM, Administrative Nurse E stated he expected staff to follow the EBP precautions for R40. Administrative Nurse E stated the door had an EBP sign for staff to follow and supplies were on the back of R40's room door. On 12/12/24 at 12:28 PM, Administrative Nurse D stated he expected staff to have proper personal protective equipment (PPE) on when a resident is on EBP, and staff should not let a resident's uncovered catheter bag touch the floor. The facility's Legionella and Legionnaires' Disease Policy, revised 06/04/24, documented the facility would identify cases of Legionnaires disease promptly to determine if the case may be associated with the facility and would report Legionnaires' disease cases to local public health authorities quickly to investigate and prevent additional infections. The facility's EBP policy, revised 06/03/24, documented EBP as indicated for residents with any of the following: 1) infection or colonization with a Centers for Disease Control (CDC) targeted Multidrug-Resistant Organisms (MDRO-bacteria that resist treatment with more than one antibiotic) when contact precautions do not otherwise apply. 2) Wounds and or indwelling medical devices if the resident is not known to be infected or colonized MDRO. 3) Indwelling medical devices including urinary catheters, feeding tubes, and tracheostomies (opening through the neck into the trachea through which an indwelling tube may be inserted). The facility failed to implement a water management program to prevent and/or mitigate risk from waterborne pathogens. The facility further failed to provide sanitary catheter care and implement EBP. This placed the residents at increased risk of contracting infectious diseases.