| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175411 | A. Building<br>B. Wing | 05/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Anew Healthcare Easton | 515 Dawson<br>Easton, KS 66020 |

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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47834<br><br>The facility identified a census of 37 residents with three residents reviewed for abuse and neglect. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 1 remained free from abuse and mistreatment. On 04/26/24 at approximately 04:10 AM, R1, who had a history of trauma and Huntington's disease (a rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder), approached Certified Nurse Aide (CNA) M and CNA O and asked for some chocolate milk saying chocky milk. R1 attempted to retrieve the milk from the refrigerator located in the residents' dining area but CNA M and CNA O instructed R1 he was not able to get the milk from the refrigerator himself and told him staff would get him the chocolate milk if he asked for it correctly. R1 continued to pull on the refrigerator door and the two CNA staff stepped in between the refrigerator and R1 and physically obstructed R1 from opening the door, which resulted in a struggle between the staff and R1. During this physical struggle, R1 kicked at the staff, attempted to stand up from his wheelchair, and subsequently fell to the ground. The CNA staff then grabbed R1 by his legs and turned him around while the staff locked the refrigerator. As a result of this mistreatment, R1 attempted to choke himself and verbalized his intent to eventually kill himself. The facility's failure to ensure R1 remained free from abuse and mistreatment placed R1 in immediate jeopardy.<br><br>Findings included:<br><br>- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of Huntington's disease, other lack of coordination, generalized muscle weakness, bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).<br><br>The Admission Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS further documented R1 used a wheelchair and was dependent on staff assistance for eating, bathing, oral hygiene, dressing, and personal hygiene. The MDS documented R1 required substantial assistance with mobility and transfers. The MDS documented no physical, verbal, or other behavioral symptoms were exhibited.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The Falls Care Area Assessment (CAA), dated 01/23/24, documented R1 had therapy services available to help with increased functional mobility and fall risk reduction. The CAA directed staff to anticipate R1's care needs so the resident would not perform unsafe activities of daily living (ADL) without staff assistance. The CAA further documented R1 had major depressive disorder, restlessness, agitation, bipolar disorder, and Huntington's disease.<br><br>R1's Care Plan with an initiated date of 02/15/24, documented R1 had an ADL self-care performance deficit related to Huntington's disease and impaired balance. Interventions with an initiated date of 2/15/24 documented R1 was dependent on staff for personal hygiene and transfers. Interventions with an initiated date of 01/29/24 directed staff to assess R1's understanding of the situation and allow time for R1 to express himself and his feelings towards the situation; when R1 became agitated staff should intervene before R1's agitation escalated. Staff should engage R1 calmly in conversation, and if R1's response was aggressive staff were directed to walk away calmly and approach later.<br><br>CNA M's Complaint Investigation Witness Statement of Facts dated 04/26/24 documented R1 came to the nurse's station and asked CNA O for some chocky milk. The statement documented CNA O responded to R1 that she did not know what chocky milk was and R1 then asked CNA M for the milk instead. The statement documented CNA M responded that she was not sure what R1 had asked for and R1 became upset and stated he would get the milk himself. CNA M documented in the statement that she told R1 he was not allowed into the refrigerator and that R1 propelled himself to the refrigerator as CNA M and CNA O followed him. CNA M documented in the statement that she waited for R1 to open the refrigerator to tell R1 again that he was not allowed in it, and then told R1 if he asked correctly, staff would get him the chocolate milk, but R1 refused to listen to the CNAs. The statement further documented R1 pulled at the refrigerator door and CNA M stepped between R1 and the refrigerator door to prevent R1 from opening it which led R1 to stand up with further attempts to open the refrigerator door. The statement further documented the CNAs attempted to prevent R1 from accessing the refrigerator when R1 began to kick CNA O and R1 later fell to the floor. CNA M documented in the statement that she locked the refrigerator door while R1 was on the floor and that R1 continued to kick CNA O. The statement documented Licensed Nurse (LN) I arrived to deescalate the situation and once the refrigerator was locked and R1 could no longer open the door, R1 threatened to kill himself and proceeded to choke himself with his hands. The statement documented R1 stated choking himself did not work, but that he would kill himself eventually. The statement further documented R1 was placed on a one-to-one direct observation after R1 refused to sit near the nurses' station for close observation after making suicidal statements. The statement documented CNA M sat outside his room to observe R1. The witness statement was signed by CNA M.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An Incident Note dated 04/26/24 at 04:20 AM documented R1 came to the nurse's station and requested chalky milk and the CNAs requested that R1 use appropriate words for what he wanted and not to use baby words. R1 responded that other staff let him use baby words. The note further documented that staff explained it could be difficult to understand and that it would have been more beneficial for him to use real words, and that R1 refused and stated he would get the milk himself. R1 propelled himself toward the refrigerator as the CNAs followed him. The note documented that LN I heard loud noises, went to investigate, and found R1 on the floor kicking into the air and cursing. The note documented LN I attempted to de-escalate the situation and R1 stood up and attempted to unlock the refrigerator. The note further documented that R1 threatened to kill himself after he was unable to unlock the refrigerator, and he placed his hands around his neck and attempted to choke himself. The note documented that R1 then stated he would kill himself eventually. The note documented that LN I placed R1 on one-to-one close observation, contacted facility leadership for guidance, contacted R1's physician, and sent R1 to the emergency room , via ambulance, due to the suicidal statements R1 made during the incident.<br><br>A Nurse Note dated 04/26/24 at 04:26 PM documented that staff spoke with R1 about the incident that occurred earlier in the morning that caused him to be sent to the emergency room . The note documented that R1 stated he was no longer suicidal and had no plan or intent to commit suicide. The note further documented staff discussed R1's triggers and his available coping skills and went over R1's trauma-informed care plan with him. The note documented R1 agreed with the care plan and voiced that he was hopeful and excited to have support from the staff.<br><br>On 04/26/24 at 02:05 PM, R1 sat in his room on his bed. R1 stated that CNA M and CNA O were rough with him the night he asked for milk, and it caused him to fall. R1 stated CNA M and CNA O no longer worked at the facility and that he felt safer there as a result.<br><br>On 04/26/24 at 02:15 PM a combined interview was conducted with LN G and LN H. LN G stated when she came on shift that morning R1 had been taken out of the facility by ambulance to be evaluated for the suicidal comments he made on the previous shift. LN G stated the CNAs knew to get the nurses when R1 had behaviors so the nurses could intervene. LN G and LN H stated R1 was redirectable, but it depended on the approach staff took when interacting with him. LN H stated if staff took the time to explain a situation to R1 he would typically respond better than if staff were short with him, or just told him no without an explanation. LN G and LN H stated residents are allowed to have items from the refrigerator 24 hours a day and that they only had to ask staff. LN H stated R1 should have been able to have the chocolate milk when he requested it.<br><br>On 04/26/24 at 02:15 PM, CNA N stated when R1 had behaviors she would walk away and get the nurse so the nurse could intervene. CNA N stated residents are allowed to have items from the refrigerator if they ask for them. CNA N stated the refrigerator was locked for infection control reasons, but if residents ask for something from the refrigerator, then staff will get it for them.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 04/26/24 at 03:47 PM Administrative Nurse D stated from her understanding of the incident R1 asked for chocolate milk but used a slang word when he asked. Administrative Nurse D stated R1 was told by staff to use big boy words and R1 then decided to get the chocolate milk himself. Staff did not want him to get the milk himself, so they followed R1 and proceeded to physically keep him out of the refrigerator. Administrative Nurse D stated while staff attempted to physically stop R1 from getting into the refrigerator, R1 fell to the floor and kicked at staff to defend himself. Administrative Nurse D stated R1 was drug and spun around by one of the CNAs so the other CNA could lock the refrigerator. Administrative Nurse D further stated the nurse heard the commotion and came to the dining hall to de-escalate the situation and that was when R1 tried to choke himself and made suicidal statements. Administrative Nurse D stated staff should have gotten up and gave R1 the chocolate milk regardless of how he asked for it. Administrative Nurse D stated R1 drinks chocolate milk often and staff knew that. Administrative Nurse D further stated it was extremely demeaning for staff to tell R1 to use his big boy voice. Administrative Nurse D stated she reviewed the video footage from the incident, and it appeared the staff were being aggressive with R1 and not R1 being aggressive with the staff. Administrative Nurse D stated she did not want the CNAs back in the facility after she viewed the video, so the CNAs were suspended and later terminated.<br><br>The facility provided an Abuse, Neglect and Exploitation policy dated 01/01/24, documented it was the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The policy further documented abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff-to-resident abuse and certain resident-to-resident altercations. Mental abuse includes but is not limited to, humiliation, harassment, threat of punishment, or deprivation.<br><br>The facility failed to ensure residents remained free from abuse and mistreatment. This deficient practice placed R1 in immediate jeopardy.<br><br>On 04/26/24 the facility completed corrective actions which included an all-staff in-service on preventing abuse, neglect, and exploitation and reporting abuse. The facility updated R1's care plan to include his past trauma and relevant interventions for staff to follow. CNA N and CNA O were not permitted back into the facility after the incident and were subsequently terminated.<br><br>The corrective actions were completed before the onsite survey therefore the deficient practice was cited as past noncompliance at a scope and severity of J. |