STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175411	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Easton	515 Dawson 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 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. 39752 The facility identified a census of 33 residents which included 23 residents with active trust accounts, held by the facility. Based on interviews and record review, the facility failed to provide Resident (R) 1 with an accurate accounting of her personal funds, when the facility overcharged R1's personal funds account by $347.89 . This placed R1 at risk for impaired autonomy and misappropriation. Findings included: - Review of R1's trust transactions as listed on the Resident Statement Landscape dated 09/01/23 to 08/26/24 documented the following duplicate charges and one charge with no receipt for R1. The withdrawals on 01/04/24 for the following amounts had handwritten receipts with R1 and Administrative Staff B's signatures for the following amounts: $20.00, $30.00, $117.89, $25.00, $30.00, and $25.00. The withdrawal on 01/31/24 for $25.00 had no receipt documented for that withdrawal. The withdrawals on 08/06/24 for the following amounts have a handwritten receipt dated from 2023 stapled to withdrawal receipts for the following amounts with receipt numbers: W000101 $117.89, W000102 $30.00, W000103 $25.00, W000104 $30.00, W000105 $25.00, and W000106 $20.00. On 08/22/24 at 04:50 PM Administrative Staff A stated that she had not reviewed the resident trust accounts. On 08/26/24 at 10:40 AM Administrative Staff B stated she did not know the job and had not received basic training to be able to handle basic situations and learned as she went. Administrative Staff B revealed she lacked understanding of the resident trust funds. On 08/26/24 at 12:15 PM Administrative Staff B looked at the trust account for R1 and realized that she entered money paid out to R1 twice, once in January and then again in August. Administrative Staff B revealed that the receipt papers had been written out by hand and then the receipts changed to a more formal form. Administrative Staff B stated that when she was putting together the receipt book for resident trust accounts earlier in August, she was entering withdrawals that Administrative Staff B thought had not been removed from R1's trust account. Administrative Staff B stated that no one looked over the resident trust accounts except for her related to the receipts and withdrawals. (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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated facility policy Transactions Involving Resident Funds documented the Business Office Manager, or his/her designee, was responsible for providing residents with receipts for withdrawals and for requested or needed personal items when such funds were withdrawn from the resident's personal funds account managed by the facility. A cope of such transactions and receipts were maintained by the Business Office Manager, or designee, to verify account transactions and to reconcile resident fund balances with withdrawals and expenditures. The Business Office Manager or designee was responsible for ensuring that resident fund accounts were reconciled on a quarterly basis and discrepancies were promptly reported to the Administrator for investigations. The policy further documented that the Business Office Manager or designee would receive periodic training on this policy to ensure that receipts for resident fund expenditures were maintained. The facility failed to provide R1 with an accurate accounting of her personal funds when the facility duplicated charges to R1's personal funds account by $347.89. This placed R1 at risk for impaired autonomy and misappropriation.

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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. 39752 The facility identified a census of 33 residents and 23 active resident trust fund accounts. The sample included five 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 08/22/24 revealed 23 total accounts with a balance of $16,931.18. The Trial Balance documented Resident (R) 2 had a current trust fund balance of $681.35. On 08/23/24 at 03:17 PM, R2's representative and responsible financial party stated he had not received a quarterly stated regarding R2's trust account at all this year. He stated that he had called and attempted to talk with the new person in charge of the trust accounts but had not been able to get ahold of anyone. On 08/26/24 at 02:40 PM Administrative Staff B confirmed 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. The undated facility policy Transactions Involving Resident Funds documented quarterly statements would be provided in writing to the resident, or the residents 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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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39752 The facility identified a census of 33 residents and 23 active resident trust fund accounts. The sample included five 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) 3, R4, and R5. This placed the residents at risk for impaired rights and misappropriation. Findings included: - Review of the Trial Balance as of [DATE] revealed 23 total accounts with a balance of 16, 931.18. The Trial Balance documented R3 had a current trust fund balance of $233.39. R3's Electronic Medical record (EMR) recorded R3 discharged from the facility on [DATE]. The Trial Balance documented R4 had a current trust fund balance of $178.95. R4's EMR recorded R4 discharged from the facility on [DATE]. The Trial Balance documented R5 had a current trust fund balance of $20.56. R5's EMR recorded he died in the facility on [DATE]. On [DATE] at 02:40 PM Administrative Staff B 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 B 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 B 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 she knew what to do with the trust accounts. Administrative Staff B said she has not received any inquiries regarding balances of trust accounts for discharged residents. The undated facility policy Transactions Involving Resident Funds lacked direction for what to do upon discharge, eviction, or death of a resident with a personal fund deposited with the facility. The facility failed to ensure the conveyance of personal funds within 30 days of discharge and/or death for R3, R4, and R5. This placed the residents at risk for impaired rights and misappropriation.

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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** 47834 The facility identified a census of 34 residents with three residents reviewed for falls and accidents. Based on record review and interview, the facility failed to ensure Resident (R) 1's safety during a transfer when Certified Nurse Aide (CNA) M and Licensed Nurse (LN) G used a Hoyer lift (total body mechanical lift) to transfer R1 from her bed to her wheelchair. During the transfer, the lift tipped, and R1 hit the back of her head on a dresser. As a result, R1 sustained a laceration to the back of her head that required staples and sutures to close. This deficient practice also placed R1 at risk for pain and other avoidable injuries. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of generalized muscle weakness, Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), cerebral infarction (stroke - 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), dependence on wheelchair, unspecified lack of coordination, and aphasia (condition with disordered or absent language function). The Annual Minimum Data Set (MDS), dated [DATE], for R1 documented the Brief Interview for Mental Status (BIMS) assessment could not be completed. The MDS documented R1 had problems with recall ability, short-term, and long-term memory. The MDS further documented R1 had severely impaired decision making and never or rarely made decisions. The MDS documented R1 used a wheelchair and was dependent on staff for all activities of daily living (ADL) including locomotion on the unit and transfers. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 01/07/24, documented R1 was alert and oriented to herself only, was unable to complete the BIMS, and required total assistance with ADLs. R1's Care Plan, with an initiated date of 11/17/17, documented R1 had a stroke, was weak, and fatigued easily. An intervention initiated on 01/02/18, documented R1 was not able to stand and required use of a Hoyer lift, with two staff assistance, for all transfers. A Fall Note dated 07/12/24, documented at 04:00 PM CNA M and LN G used the Hoyer lift to transfer R1 from the bed to her wheelchair and the Hoyer lift tipped in the middle of the transfer. The note documented CNA M and LN G lowered R1 to the floor and on the way down, the back of R1's head hit the corner of a dresser. The note further documented that R1 suffered a laceration to the back of her head related to the fall, and was transported to the emergency room . A Nurse Note dated 07/12/24, documented the facility received report from the emergency room about R1's condition. The note further documented R1 required seven staples and three sutures to the back of her head. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA M's Complaint Investigation Witness Statement dated 07/12/24, documented CNA M asked LN G to help transfer R1 from her bed to her Broda chair (specialized wheelchair with the ability to tilt and recline) and the lift tipped in the middle of the transfer. The statement documented CNA M and LN G lowered R1 to the floor and R1 hit the back of her head on the corner of a dresser. An undated Entity Reports and Complaint Data Collection form documented on 07/12/24 at 04:00 PM, LN G and CNA M transferred R1 via Hoyer lift from her bed to her wheelchair when the lift tipped in the middle of the transfer. The report documented staff attempted to lower R1 to the floor and the back of R1's head hit the corner of the dresser. The reported documented 911 was called and R1 was transported to an emergency room . The report documented the Hoyer lift was removed from use in the facility until a mechanical and physical evaluation was completed and the maintenance director was notified. Review of the CCI Monthly Lift Safety Maintenance Checklist for April 2024 to July 2024 revealed the facility had three lifts that were inspected. The checklists lacked evidence there were any issues with the lifts. R1 was unavailable for observation. On 07/16/24 at 12:50 PM Administrative Nurse D stated she was unsure if staff completed Hoyer lift training prior to R1's fall from the lift. Administrative Nurse D stated CNA M and LN G were hired before her and the previous person responsible for staff education no longer worked at the facility. Administrative Nurse D looked for the education files and stated there were no records of the LN completing Hoyer lift training at the facility. Administrative Nurse D stated the lift training for CNA M was filled out by the previous employee, that provided education for staff; however, it was not signed by CNA M to show it was complete. Administrative Nurse D stated she had lift training scheduled on 07/25/24. She stated some training was completed after R1's fall; however, she wanted to have additional training to go though everything more in depth with staff. Administrative Nurse D stated lift training would be added to the facility's yearly education as part of staff yearly competencies in October going forward. On 07/16/24 at 01:14 PM LN G stated she was not sure what caused the lift to tip to the right and said it happened fast. LN G stated R1 did not have a hard landing on the floor as her and CNA M were able to get a hold of R1; however, she stated they were not able to move R1 over enough to clear the corner of the dresser during the fall which resulted in R1 hitting her head. LN G stated the legs of the lift were open while she transferred R1, and they appeared to be open all the way. She stated the legs should be open to provide a wide base and stated she was not sure why it tipped. LN G stated there was nothing that indicated the lift was not working correctly, and if she had noticed an issue with the lift, she would have stopped with the transfer and switched lifts. LN G stated she received lift training when she hired on about 14 to 15 months ago. LN G stated she was unsure who would have provided the training previously as so many people have changed positions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 07/16/24 at 01:30 PM CNA N stated she worked at the facility for about four months and had been a CNA for nine years. CNA N stated she had not received lift training at the facility but had received lift training at a previous facility. CNA N stated the facility asked if she had prior training and knew how to operate a Hoyer lift when she hired on, but she was not asked to demonstrate that she knew how to properly use one. CNA N stated she had not noticed any issue with any of the Hoyer lifts in the facility other than the occasional dead battery from not being charged. CNA N stated if there was an issue with one of the lifts it would have been taken out of service, so no one used it, and placed in the maintenance book. CNA N stated she moved the Hoyer lift with the legs strait while placing the lift under the bed, as there was no room to open the legs due to the structure of the bed. She stated after the resident was raised in the lift, she pulled the lift straight out and turned the lift while the legs were straight. She stated she opened the legs once the wheelchair was in place. On 07/16/24 at 03:03 PM Administrative Nurse D stated she worked on more education for staff that day. Administrative Nurse D stated she went over the lift user guide and the Food and Drug Administration (FDA) patient lift safety guide with the staff today. She stated she had one staff member left to provide training for. Administrative Nurse D stated she trained staff to keep the legs out, and not together, while moving a resident in the lift. The undated, facility provided Safe Resident Handling/Transfers policy documented it is the policy of the facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with the current standard and guidelines. The facility failed to ensure R1's safety during a transfer when CNA M and LN G used a Hoyer lift to transfer R1 from her bed to her wheelchair. During the transfer, the lift tipped, and R1 hit the back of her head on a dresser. As a result, R1 sustained a laceration to the back of her head that required staples and sutures to close. This deficient practice also placed R1 at risk for pain and other avoidable injuries.