STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175450	A. Building B. Wing	04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Oxford	200 S Ohio St Oxford, KS 67119

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 - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 32235 The facility reported a census of 29 residents. The facility failed to ensure the resident's remained free from verbal and mental abuse which included threat of bodily harm and retaliation on 04/04/23 when Administrative Staff A stated to staff during a morning meeting, she would get a gun and blow this place up if [Resident (R) 1] fell on e more time. The facility staff who witnessed this threat of bodily harm, abuse, and retaliation against the residents and the staff did not contact Corporate Staff or local law enforcement. This failure allowed Administrative Staff A to continue her presence in the facility around all of the residents and staff. Other facility staff were made aware of the threatening statement made by Administrative Staff A and did not report to facility administration, Corporate Staff, or local law enforcement. As a result, the residents became aware of the threatening statement, which made the residents afraid for their personal safety and fearful to remain in the facility, which had a negative psychosocial impact on the residents. This failure placed all residents in Immediate Jeopardy. Findings Included: - R1's Admission Physician Order dated 03/07/23 revealed diagnoses of anxiety, depression, unspecified dementia (progressive mental disorder characterized by failing memory, confusion), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and hemiplegia (paralysis of one side of the body) following cerebral infraction (CVA is a sudden death of brain cells due to lack of oxygen), affecting the right dominant side. The 03/10/23 Fall Care Plan revealed R1 was high risk for falls related to gait (manner or style of walking), balance problems, poor communication and comprehension, and poor safety awareness. R1 had a history of CVA with right sided weakness and Parkinson's. The care plan revealed R1 had multiple falls sine admission. Review of the Electronic Medical Record recorded R1 fell on the following dates: 03/17/23, 03/19/23, 03/21/23, 03/24/23, 03/25/23, 03/28/23, and 04/03/23. On 04/06/23 at 11:23 AM an interview with R2 revealed Administrative Staff A told her she was not to use her call light for staff assistance, as she was using the aides too much. She stated staff told her Administrative Staff A threatened to blow the place up if R1 fell on e more time. R2 stated she was scared and did not feel safe in the facility with Administrative Staff A. (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Many	On 04/06/23, per email interview, Certified Nurse Aide (CNA) N revealed staff and residents were scared after hearing Administrative Staff A told other staff she would get a gun and blow up the place if [R1] fell again. She emailed the corporate office on 04/04/23 regarding the incident and received an email back on 04/04/23 at 09:58 PM stating Thank you, I will investigate. CNA N stated other staff were scared and upset. An interview on 04/06/23 at 02:47 PM, an anonymous staff member revealed she was unsure how to report the administrator or who to report her to. She stated Administrative Staff A was rude to residents she did not care for. This staff member further revealed she witnessed Administrative Staff A yell at R3 a few months ago, stating he was moving out of his room and there was nothing he could do about it. On 04/06/23 at 03:52 PM, Licensed Nurse G confirmed Administrative Staff A was rude with staff and residents at times. During an interview on 04/06/23 at 01:04 PM, Administrative Staff A confirmed she made the statement regarding shooting up the place, and stated it was an off-color comment. Administrative Staff A stated she would not say things like that again. During a phone interview on 04/06/23 at 01:12 PM, Administrative Staff B stated Administrative Staff A would be removed from the building and they would start an investigation. The facility's Abuse, Neglect and Exploitation policy with a revision/implemented date of 03/07/23 revealed it was the policy of the facility to provide protection 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 facility failed to ensure the resident's remained free from verbal and mental abuse which included threat of bodily harm and retaliation on 04/04/23 when Administrative Staff A stated to staff during a morning meeting, she would get a gun and blow this place up if [Resident (R) 1] fell on e more time. The facility provided an acceptable plan of removal on 04/07/23 at 07:59 PM after completing the following: 1. Administrative Staff A was removed from the facility at approximately 01:30 PM. 2. The facility notified the [NAME] Police Department on 04/06/23 at 2 PM and at 6 PM regarding the threat of bodily harm. 3. The medical director was contacted on 04/06/23 at 6 PM 4. A thorough investigation was completed to determine residents with a BIMS of 13 or higher and interviewed. There were no negative results given from the 15 interviewable residents. 5. Immediate re-education was provided to all staff members on 04/06/23 and 04/07/23 regarding Workplace Violence Prevention, Threatening or Violent Behavior in the workplace, Active Shooter/Violent Incidents. The education contained competency training. (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 - Immediate jeopardy to resident health or safety Residents Affected - Many	The immediate jeopardy was removed on 04/10/23 at 12:00 PM, when the surveyor verified implementation of the correction actions. The deficient practice remained at a scope and severity of a F after removal of the immediate jeopardy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 32235 The facility reported a census of 29 residents. The facility failed to ensure the resident's remained free from verbal and mental abuse which included threat of bodily harm and retaliation on 04/04/23 when Administrative Staff A stated to staff during a morning meeting, she would get a gun and blow this place up if [Resident (R) 1] fell on e more time. The facility staff who witnessed this threat of bodily harm, abuse, and retaliation against the residents and the staff did not contact Corporate Staff or local law enforcement. This failure allowed Administrative Staff A to continue her presence in the facility around all of the residents and staff. Other facility staff were made aware of the threatening statement made by Administrative Staff A and did not report to facility administration, Corporate Staff, or local law enforcement. The facility failed to investigate this allegation made by Administrative Staff A. As a result, the residents became aware of the threatening statement, which made the residents afraid for their personal safety and fearful to remain in the facility, which had a negative psychosocial impact on the residents. This failure placed all residents in Immediate Jeopardy. Findings Included: - R1's Admission Physician Order dated 03/07/23 revealed diagnoses of anxiety, depression, unspecified dementia (progressive mental disorder characterized by failing memory, confusion), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and hemiplegia (paralysis of one side of the body) following cerebral infraction (CVA- sudden death of brain cells due to lack of oxygen), affecting the right dominant side. The 03/10/23 Fall Care Plan revealed R1 was high risk for falls related to gait (manner or style of walking), balance problems, poor communication and comprehension, and poor safety awareness. R1 had a history of CVA with right sided weakness and Parkinson's. The care plan revealed R1 had multiple falls sine admission. Review of the Electronic Medical Record recorded R1 fell on the following dates: 03/17/23, 03/19/23, 03/21/23, 03/24/23, 03/25/23, 03/28/23, and 04/03/23. On 04/06/23 at 11:23 AM an interview with R2 revealed Administrative Staff A told her she was not to use her call light for staff assistance, as she was using the aides too much. She stated staff told her Administrative Staff A threatened to blow the place up if R1 fell on e more time. R2 stated she was scared and did not feel safe in the facility with Administrative Staff A. On 04/06/23, per email interview, Certified Nurse Aide (CNA) N revealed staff and residents were scared after hearing Administrative Staff A told other staff she would get a gun and blow up the place if [R1] fell again. She emailed the corporate office on 04/04/23 regarding the incident and received an email back on 04/04/23 at 09:58 PM stating Thank you, I will investigate. CNA N stated other staff were scared and upset. (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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview on 04/06/23 at 02:47 PM, an anonymous staff member revealed she was unsure how to report the administrator or who to report her to. She stated Administrative Staff A was rude to residents she did not care for. This staff member further revealed she witnessed Administrative Staff A yell at R3 a few months ago, stating he was moving out of his room and there was nothing he could do about it. On 04/06/23 at 03:52 PM, Licensed Nurse G confirmed Administrative Staff A was rude with staff and residents at times. During an interview on 04/06/23 at 01:04 PM, Administrative Staff A confirmed she made the statement regarding shooting up the place, and stated it was an off-color comment. Administrative Staff A stated she would not say things like that again. During a phone interview on 04/06/23 at 01:12 PM, Administrative Staff B stated Administrative Staff A would be removed from the building and they would start an investigation. The facility's Abuse, Neglect and Exploitation policy with a revision/implemented date of 03/07/23 revealed it was the policy of the facility to provide protection 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 facility failed to ensure the resident's remained free from verbal and mental abuse which included threat of bodily harm and retaliation on 04/04/23 when Administrative Staff A stated to staff during a morning meeting, she would get a gun and blow this place up if [Resident (R) 1] fell on e more time. The facility provided an acceptable plan of removal on 04/07/23 at 07:59 PM after completing the following: 1. Administrative Staff A was removed from the facility at approximately 01:30 PM. 2. The facility notified the [NAME] Police Department on 04/06/23 at 2 PM and at 6 PM regarding the threat of bodily harm. 3. The medical director was contacted on 04/06/23 at 6 PM 4. A thorough investigation was completed to determine residents with a BIMS of 13 or higher and interviewed. There were no negative results given from the 15 interviewable residents. 5. Immediate re-education was provided to all staff members on 04/06/23 and 04/07/23 regarding Workplace Violence Prevention, Threatening or Violent Behavior in the workplace, Active Shooter/Violent Incidents. The education contained competency training. The immediate jeopardy was removed on 04/10/23 at 12:00 PM, when the surveyor verified implementation of the correction actions. The deficient practice remained at a scope and severity of a F after removal of the immediate jeopardy.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32235 The facility reported a census of 29 residents. The facility failed to ensure the resident's remained free from verbal and mental abuse which included threat of bodily harm and retaliation on 04/04/23 when Administrative Staff A stated to staff during a morning meeting, she would get a gun and blow this place up if [Resident (R) 1] fell on e more time. The facility staff who witnessed this threat of bodily harm, abuse, and retaliation against the residents and the staff did not contact Corporate Staff or local law enforcement. This failure allowed Administrative Staff A to continue her presence in the facility around all of the residents and staff. Other facility staff were made aware of the threatening statement made by Administrative Staff A and did not report to facility administration, Corporate Staff, or local law enforcement. The facility failed to investigate this allegation made by Administrative Staff A. As a result, the residents became aware of the threatening statement, which made the residents afraid for their personal safety and fearful to remain in the facility, which had a negative psychosocial impact on the residents. This failure placed all residents in Immediate Jeopardy. Findings Included: - R1's Admission Physician Order dated 03/07/23 revealed diagnoses of anxiety, depression, unspecified dementia (progressive mental disorder characterized by failing memory, confusion), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and hemiplegia (paralysis of one side of the body) following cerebral infraction (sudden death of brain cells due to lack of oxygen), affecting the right dominant side. The 03/10/23 Fall Care Plan revealed R1 was high risk for falls related to gait (manner or style of walking), balance problems, poor communication and comprehension, and poor safety awareness. R1 had a history of CVA with right sided weakness and Parkinson's. The care plan revealed R1 had multiple falls sine admission. Review of the Electronic Medical Record recorded R1 fell on the following dates: 03/17/23, 03/19/23, 03/21/23, 03/24/23, 03/25/23, 03/28/23, and 04/03/23. On 04/06/23 at 11:23 AM an interview with R2 revealed Administrative Staff A told her she was not to use her call light for staff assistance, as she was using the aides too much. She stated staff told her Administrative Staff A threatened to blow the place up if R1 fell on e more time. R2 stated she was scared and did not feel safe in the facility with Administrative Staff A. On 04/06/23, per email interview, Certified Nurse Aide (CNA) N revealed staff and residents were scared after hearing Administrative Staff A told other staff she would get a gun and blow up the place if [R1] fell again. She emailed the corporate office on 04/04/23 regarding the incident and received an email back on 04/04/23 at 09:58 PM stating Thank you, I will investigate. CNA N stated other staff were scared and upset. (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 - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview on 04/06/23 at 02:47 PM, an anonymous staff member revealed she was unsure how to report the administrator or who to report her to. She stated Administrative Staff A was rude to residents she did not care for. This staff member further revealed she witnessed Administrative Staff A yell at R3 a few months ago, stating he was moving out of his room and there was nothing he could do about it. On 04/06/23 at 03:52 PM, Licensed Nurse G confirmed Administrative Staff A was rude with staff and residents at times. During an interview on 04/06/23 at 01:04 PM, Administrative Staff A confirmed she made the statement regarding shooting up the place, and stated it was an off-color comment. Administrative Staff A stated she would not say things like that again. During a phone interview on 04/06/23 at 01:12 PM, Administrative Staff B stated Administrative Staff A would be removed from the building and they would start an investigation. The facility's Abuse, Neglect and Exploitation policy with a revision/implemented date of 03/07/23 revealed it was the policy of the facility to provide protection 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 facility failed to ensure the resident's remained free from verbal and mental abuse which included threat of bodily harm and retaliation on 04/04/23 when Administrative Staff A stated to staff during a morning meeting, she would get a gun and blow this place up if [Resident (R) 1] fell on e more time. The facility provided an acceptable plan of removal on 04/07/23 at 07:59 PM after completing the following: 1. Administrative Staff A was removed from the facility at approximately 01:30 PM. 2. The facility notified the [NAME] Police Department on 04/06/23 at 2 PM and at 6 PM regarding the threat of bodily harm. 3. The medical director was contacted on 04/06/23 at 6 PM 4. A thorough investigation was completed to determine residents with a BIMS of 13 or higher and interviewed. There were no negative results given from the 15 interviewable residents. 5. Immediate re-education was provided to all staff members on 04/06/23 and 04/07/23 regarding Workplace Violence Prevention, Threatening or Violent Behavior in the workplace, Active Shooter/Violent Incidents. The education contained competency training. The immediate jeopardy was removed on 04/10/23 at 12:00 PM, when the surveyor verified implementation of the correction actions. The deficient practice remained at a scope and severity of a F after removal of the immediate jeopardy.

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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 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** 32235 The facility reported a census of 29 residents. The sample included five residents with three reviewed for falls. Based on observation, interview, and record review the facility failed to identify and implement fall interventions to prevent falls for Resident (R) 1, who had cognitive decline and multiple falls. One of R1's falls resulted in a subdural hematoma (collection of blood on the surface of the brain) and required hospitalization . This placed R1 at risk for further falls and avoidable injury. Findings Included: - R1's Admission Physician Order dated 03/07/23 revealed diagnoses of anxiety, depression, unspecified dementia (progressive mental disorder characterized by failing memory, confusion), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and hemiplegia (paralysis of one side of the body) following cerebral infraction (sudden death of brain cells due to lack of oxygen) affecting the right dominant side. The 03/23/23 Five-Day Minimum Data Set (MDS) revealed R1 had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severe cognitive impairment. It further revealed the resident required extensive assistance of two staff for all activities of daily living (ADL), and R1 had two non-injury falls since admission. The Significant Change Minimum Data Set, dated dated dated [DATE], was still in progress and no Care Area Assessments were available. The Falls Care Plan initiated on 03/10/23 revealed R1 was a high risk for falls related to gait (manner or style of waking)/balance problems, poor communication/comprehension, and poor safety awareness. The care plan revealed R1 had a history of Cerebral Vascular Accident (CVA/stroke) with right sided weakness and Parkinson's disease. The care plan revealed R1 had many multiple falls since admission. The care plan revisions included the following interventions: 03/28/23: ensure bed was in the lowest position. 03/28/23: ensure resident was dry and comfortable when placed in her bed. 03/28/23: ensure the resident wore appropriate footwear when ambulating. 03/28/23: foam mat by bed. 03/28/23: follow facility fall protocol. 03/28/23 resident readmitted from hospital following stroke with right sided weakness. Physical Therapy (PT)/Occupational Therapy (OT)/Speech Therapy (ST) to evaluate and treat. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	03/28/23: review information on past falls and attempt to determine cause of falls. Record possible root cause. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT to causes. 03/28/23: communication board to assist resident with communication- ask yes/no questions, revised on 04/05/23. 04/04/23: offer food and drink frequently when awake. 04/04/23: resident to utilize light weighted blanket over her lap when up in the chair. Review of the Electronic Medical Record (EMR) under Nurses Notes revealed the following: A Nurses Note on 03/11/23 at 01:09 PM revealed the resident was on follow-up for a fall after the nurse was informed of a fall that occurred before the nurse arrived. The resident complained of pain to her back in between her shoulders, with no visible injury noted. Staff observed R1 sitting at the dining room table. The record lacked documentation of the fall occurring. A Nurses Note on 03/13/23 at 01:26 AM revealed the nurse was summoned to the resident's room by Direct Care Staff. The nurse found the residing in the bathroom on the toilet. The resident was okay and talking. The nurse asked the resident what happened, R1 reported she lost her balance when she walked to the bathroom. R1 reported she was not hurt and did not hit her head on the wall. R1's roommate reported R1 fell when R1 ambulated to the bathroom without assistance. R1's roommate stated R1 fell in front of the dresser and hit her back and landed on her bottom, got herself up and continued to the restroom. The roommate initiated the call light to get staff's attention. The staff assisted R1 back to her bed via the wheelchair. The nurse educated R1 on call light use, the Assistant Director of Nursing, physician, and Durable Power of Attorney were notified. R1's bed was placed in the lowest position with the call light in reach. The note further revealed the nurse would have the day shift make a sign to be placed on the resident's side table, educating the resident to call for assistance to the bathroom or when getting out of bed. Nurse's Notes from 03/13/23 thru 03/16/23 revealed the resident was in the hospital due to having a stroke. Nurse's Note on 03/17/23 at 04:54 PM revealed R1 was found on the floor next to bed. The note revealed her bed was in lowest position, and R1 was without clothing and had no visible injuries noted. A Fall Note dated 03/19/23 at 03:04 PM revealed the resident was found on the floor near the bed, she laid on her right side on a foam mat. R1 was alert without signs of injury. Her pants and briefs were pulled down to her upper thigh, she was incontinent of bowel. Interventions placed included to continue with low bed, floor mat, education on call light, check and change if needed before putting resident in bed. (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 0689 Level of Harm - Actual harm Residents Affected - Few	A Fall Note dated 03/21/23 at 05:42 PM, revealed a resident notified staff R1 was on the floor in the commons area. R1 was found on her right side on the floor. R1 denied pain and was assisted up with two staff to her wheelchair. Resident was last seen at 04:30 PM in the common room and sat in a recliner. The note further revealed R1 could not state what happened. She could use her walker and assistance from one staff with ambulation. The note revealed R1 was impulsive and underestimated her own limits. A Fall Note dated 03/24/23 at 04:00 PM revealed R1 sat in the dining room at the table with wheels locked. R1 unlocked the wheel and backed away from the table. R1 leaned over in the wheelchair and fell . The immediate intervention placed was R1 would be placed at dining room table with wheels locked and in direct view of staff. On 03/25/23 at 11:09 PM the resident sat outside the nurse's station and attempted to stand R1 fell and hit the floor on her right side. Bruise noted to right temple. The nurse asked resident what she was doing, the resident was unable to answer. The nurse and two direct care staff assisted the resident to her wheelchair with a gait belt and put her to bed. The bed was placed in the lowest position and the call light was placed in reach. R1 was educated on the use of the call light. On 03/26/23 at 12:03 PM, a Nurse's Note revealed R1 did not want to eat or drink at breakfast. At 10:00 AM a staff revealed to the nurse that R1 was not doing well and complained of pain to head. The physician extender was notified, and an order was given for chest Xray. From 10:00 AM until 11:25 AM the resident was in bed, was placed on oxygen at 2 liters per nasal canula due to oxygen saturation between 81 percent and 91 percent. The nurse obtained pain medication and gave to resident. The note further revealed that the R1 was drowsy and responded to touch. The physician extender was notified again and ordered to send R1 to the emergency room of choice. The resident left by ambulance at 12:00 PM for the emergency room . On 03/26/23 at 3:53 PM, A Nurses Note revealed the hospital emergency room called and stated R1 had a subdural hematoma (collection of blood on the surface of the brain) and was being transferred to another hospital. The resident returned to the facility on [DATE] at 5:34 PM with no new orders. On 03/28/23 at 5:50 AM A Nurses Note revealed the nurse was called to R1's room and found the resident on her left side on the floor. The resident did not have a gown on, and her brief was partially off. The resident was laying on her left side with bed beside the bed and her head on the floor. The note revealed that R1 was not able to state what happened. Intervention placed at this time was more frequent checks and have ordered a camera for her room. On 03/28/23 at 12:11 PM a Nurses Note revealed orders were received to send R1 to the emergency room . A Nurses Note on 04/01/23 at 2:20 PM, R1 returned to the facility with an order for hospice. On 04/03/23 at 08:07 PM the Nurses Note revealed the nurse was summoned to the common area to find R1 laying on her left side. Resident had a small red area to left knee and old, yellow bruising to the right side of her head. Resident was lethargic and responded slowly to verbal stimuli. The resident was assisted to the wheelchair by two staff and then placed in her bed in her room. Bed placed in lowest position and call light in reach. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175450	A. Building B. Wing	04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Oxford	200 S Ohio St Oxford, KS 67119

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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 0689 Level of Harm - Actual harm Residents Affected - Few	The Hospital Discharge Summary dated 03/27/23 revealed the following discharge diagnosis of trauma fall, subdural hematoma, MCA Stroke (approximately 3 weeks ago). The discharge summary revealed she was brought to the emergency department after decreased alertness and a 2 millimeter (mm) noted by imagery. The summary revealed she had had several falls over the last few days. She had decreased level of alertness and was sleepy. The Fall Risk assessment dated [DATE] revealed a score of 75, which indicated high risk for falls. The fall log was requested from Administrative Staff A for falls that had occurred since January 2023. R1 was only on the list one time. An observation on 04/06/23 at 10:08 AM revealed R1 was in her room and laid in her bed. The bed was at the lowest position, and there was a mat on the floor next to the bed. R1's eyes were closed, she wore a gown, and did not have a blanket on her. The call light was strapped around a small bed rail and not within reach of the resident. A small golden bell was on the resident's nightstand and not in reach of the resident. A small camera was in use on the nightstand. An observation at approximately 10:30 AM on 04/06/23 revealed the nurses station room was without staff to monitor the camera that was placed in R1's room. An observation on 04/06/23 at 12:50 PM revealed R1 was in her room and laid in her bed. R1's bed was in the lowest position with a fall mat to the side. R1 laid on her right side, her eyes were closed, she was dressed in a gown and without a blanket. Neither R1's call light, nor the golden bell, were within her reach. An interview on 04/06/23 at 12:04 PM with Certified Nurse Aide (CNA) O revealed R1 had multiple falls in the last few weeks. CNA O stated R1 was not able to use the call light anymore, however they did have a bell that she could use if she was given it. CNA O further stated R1 became restless when she was wet or dirty, so they try and keep her clean. An interview on 04/06/23 at 02:47 PM with CNA N revealed R1 fell frequently. CNA N stated R1 was not able to use the call bell or the other bell they had for her. CNA N stated there was a monitor in her room and if someone was in the nurse's station, they monitored it. She further stated R1 needed to be checked frequently. An interview on 04/06/23 at 03:54 PM with Licensed Nurse (LN) G revealed R1 was often restless, and the staff had tried multiple interventions to keep her from falling. LN G further stated she was a new hire to the facility and was not aware of all the falls R1 had previously. An interview conducted by email on 04/11/23, with Administrative Nurse D revealed the fall checklist was an internal form nursing staff used to remind them what all needed to be completed with falls. Nursing staff are to put an intervention in place following a fall. If the nurse did not place an intervention at the time of the fall, then the Interdisciplinary Team would put one in place when the fall was reviewed in morning meeting. Administrative Nurse C further revealed that the intervention of use of the call light was appropriate at the time of R1's fall on 03/11/23, but her cognition had declined, and it would not be appropriate and stated other interventions had been placed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Fall Policy implemented on 04/02/23 revealed all residents would receive adequate supervision, assistance and assistive devices to aid in the prevention of falls. All falls were to be investigated and monitored. The facility would maintain a record that contained a list of incidents and falls. The recording trends were reported and discussed at Quality Assurance Risk Management Committee Meetings monthly and quarterly. The facility failed to identify and implement fall interventions to prevent falls for R1, who had cognitive decline and multiple falls. One of R1's falls resulted in a subdural hematoma and required hospitalization .

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 32235 The facility reported a census of 29 residents. Based on observation, interview and record review the facility failed to provide administrative services in a manner to effectively and efficiently use resources to attain/maintain each resident's highest physical, mental, and psychosocial well-being, for all 29 residents that resided in the facility. Findings Included: - The facility reported a census of 29 residents. The facility failed to ensure the resident's remained free from verbal and mental abuse which included threat of bodily harm and retaliation on 04/04/23 when Administrative Staff A stated to staff during a morning meeting, she would get a gun and blow this place up if [Resident (R) 1] fell on e more time. The facility staff who witnessed this threat of bodily harm, abuse, and retaliation against the residents and the staff did not contact Corporate Staff or local law enforcement. This failure allowed Administrative Staff A to continue her presence in the facility around all of the residents and staff. Other facility staff were made aware of the threatening statement made by Administrative Staff A and did not report to facility administration, Corporate Staff, or local law enforcement. As a result, the residents became aware of the threatening statement, which made the residents afraid for their personal safety and fearful to remain in the facility, which had a negative psychosocial impact on the residents. This failure placed all residents in Immediate Jeopardy. (See F600) The facility reported a census of 29 residents. The facility failed to ensure the resident's remained free from verbal and mental abuse which included threat of bodily harm and retaliation on 04/04/23 when Administrative Staff A stated to staff during a morning meeting, she would get a gun and blow this place up if [Resident (R) 1] fell on e more time. The facility staff who witnessed this threat of bodily harm, abuse, and retaliation against the residents and the staff did not contact Corporate Staff or local law enforcement. This failure allowed Administrative Staff A to continue her presence in the facility around all of the residents and staff. Other facility staff were made aware of the threatening statement made by Administrative Staff A and did not report to facility administration, Corporate Staff, or local law enforcement. The facility failed to investigate this allegation made by Administrative Staff A. As a result, the residents became aware of the threatening statement, which made the residents afraid for their personal safety and fearful to remain in the facility, which had a negative psychosocial impact on the residents. This failure placed all residents in Immediate Jeopardy. (See F609) (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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility reported a census of 29 residents. The facility failed to ensure the resident's remained free from verbal and mental abuse which included threat of bodily harm and retaliation on 04/04/23 when Administrative Staff A stated to staff during a morning meeting, she would get a gun and blow this place up if [Resident (R) 1] fell on e more time. The facility staff who witnessed this threat of bodily harm, abuse, and retaliation against the residents and the staff did not contact Corporate Staff or local law enforcement. This failure allowed Administrative Staff A to continue her presence in the facility around all of the residents and staff. Other facility staff were made aware of the threatening statement made by Administrative Staff A and did not report to facility administration, Corporate Staff, or local law enforcement. The facility failed to investigate this allegation made by Administrative Staff A. As a result, the residents became aware of the threatening statement, which made the residents afraid for their personal safety and fearful to remain in the facility, which had a negative psychosocial impact on the residents. This failure placed all residents in Immediate Jeopardy. (See F610) The facility reported a census of 29 residents. The sample included five residents with three reviewed for falls. Based on observation, interview, and record review the facility failed to identify and implement fall interventions to prevent falls for Resident (R) 1 with cognitive decline, who had multiple falls. One fall resulted in R1 having a subdural hematoma and required hospitalization . This placed R1 at risk for further falls and avoidable injury. (See F689) The facility failed to provide administrative services in a manner to effectively and efficiently use resources to attain/maintain each resident's highest physical, mental, and psychosocial well-being, for all 29 residents that resided in the facility.