STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175416	A. BUILDING _____ B. WING _____	**08/21/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELMHAVEN WEST NURSING HOME	**1315 S 15TH ST PARSONS, KS 67357**

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 0157 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 31 residents, with 4 residents sampled for accidents. Based on interview and record review, the facility failed to notify the physician of an accident with injury and change in condition requiring physician intervention for 1 of the 4 sampled residents (#1) whose fall resulted in a Subdural Intracranial Hematoma (an accumulation of blood in the subdural space). Findings included: - The physician order [REDACTED].#1 re-admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The care plan, last updated 5/26/14, identified the resident as a Fall Risk with the following interventions: Assure the floor is free of glare, liquids, foreign objects; Encourage resident to assume a standing position slowly; Encourage resident to use environmental devices such as hand grips, hand rails, etc.; Keep call light in reach at all times; Keep personal items and frequently used items within reach; Obtain PT (physical therapy) consult for strength training, toning, positioning, transfer training, gait training, mobility devices, etc.; Provide proper, well-maintained footwear; Provide resident an environment free of clutter; Provide toileting assistance every 2 hours and PRN (as needed). The Nursing Order (an order placed based on nursing judgment), dated 8/1/14, (at admission) documented tag alarm on at all times, every shift and dated 8/9/14, (after the fall) documented chair alarm at all times, every shift. The medical record lacked any MDS (minimum data set) data. The nurse's note, dated 8/9/14 at 3:30 PM, documented this nurse went to the resident's room, the resident was not in his/her room and the wheelchair was found outside of the closed bathroom door. The resident's personal body alarm was still attached to the chair. The nurse knocked on the bathroom door asking if the resident was okay? The resident replied with Yes, I'm fine and I'll be done in a minute when asked multiple times. The resident then said, Well, maybe you should come in here. Staff found the resident lying on his/her right side in front of the toilet with his/her hand and head just next to the call light pull string. The resident was alert and oriented x 3 and denied any pain, discomfort, or hitting his/her head. The resident ' s upper and lower ROM (range of motion) was within normal limits for resident. Staff assisted the resident into the wheelchair by this nurse and 3 staff members. When asked why he/she did not get assistance with going to the bathroom the reply was I didn't need any. When asked how he/she fell to the floor the reply was, I don't know, I just tumbled over. Vital Signs (VS)-blood pressure (B/P) 118/64 (normal 90-140/60-90), temperature (temp) 97.9 (normal < 98.6 in geriatric population), respirations (resp) 18 (normal 12-20), Heart Rate (HR) 58 (normal 60-100), Oxygen Saturation (O2) 99% (normal 95-100%) and Blood Sugar (BS) 107 (normal 70-100). During further assessment, the resident stated he/she Must have bumped my head. Staff noted a small bruise and bump to the back of the resident's head, just below the hairline. PERRLA (pupils equal, round, reactive to light and accommodation) and grips equal. The resident denied N/V (nausea and vomiting) (PERRLA, grips and N/V were partial components of a thorough neurological assessment). Staff notified the physician by fax and left a message for the resident ' s DPOA (durable power of attorney) to contact the facility. The notification to the physician of the fall, dated 8/9/14 at 5:37 PM (after normal business hours on a Saturday), sent by fax to the physician ' s office, documented the resident had fallen and hit his/her head with a bruise and bump on the back of the head just below the hairline, denies pain or discomfort. The nurse's note, dated 8/10/14 at 7:15 AM, documented the resident lying on the left side with his/her head elevated. When asked, the resident was able to state name and what city we were in, but stated that this nurse was his/her mother and was unable to state his/her location. The resident's speech/conversation did not make sense and the resident complained of shortness of breath, denied any pain at this time, will continue to monitor. The record lacked any notification to the physician of this change in condition. The nurse's note, dated 8/10/14 at 8:20 AM, documented the resident transferred to the hospital via facility staff. Review of the medical record revealed the record lacked any notification to the physician related to the ongoing changes in condition for this resident. Furthermore, the physician was notified of the fall with head injury only by fax on 8/9/14, a Saturday when the physician office is closed. The physician was not phoned and spoken to in person. On 8/12/14 at 1:15 PM, Licensed Nursing Staff E reported that whenever there is a fall, the nurse should notify the physician by phone, you need to talk to them, especially if the resident suffered a fall with injury, hit their head or has any abnormalities with the post assessment or change of condition. On 8/12/14 at 1:53 PM, Administrative Nursing Staff C reported that the expectation of the nurse after a resident falls is to notify the physician. Staff C reported if it is a weekend and there is an injury, the nurse should not fax, but call and speak to the physician or physician on call in person. On 8/12/14 at 5:15 PM, Administrative Staff A reported that it is not acceptable to send a fax only to the physician after a fall with head injury, especially if it is a weekend when the office is closed. On 8/12/14 at 5:50 PM, Administrative Nursing Staff B confirmed the nurse should make phone contact with physician or physician on call after a fall with injury, especially head injury. Staff B reported it is not acceptable to fax physician office on the weekend, when they are closed, especially with conditions such as an injury or the resident hit their head. The facility provided a policy for Significant Status Change Documentation, not dated, which documented to assure the physician is notified of change, nurse's full head to toe assessment, and if there are any nursing interventions that are implemented. The facility failed to notify the physician of an accident with injury and change in condition requiring physician intervention for this resident whose fall resulted in a Subdural Intracranial Hematoma (an accumulation of blood in the subdural space).

F 0225 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 31 residents, with 4 residents sampled for accidents. Based on interview and record review, the facility failed to investigate and report to the State agency an incident of alleged neglect involving 1 of the sampled resident's (#1) who suffered a fall with head injury that resulted in a subdural intracranial hematoma (an accumulation of blood in the subdural space) and the resident expired at the hospital. Findings included: - The physician order [REDACTED].#1 readmitted to the facility [DATE] with Diagnosis: [REDACTED]. The nurses note, dated [DATE] at 3:30 PM, documented this nurse went to the resident's room, the resident was not in his/her room and the wheelchair was found outside of the closed bathroom door. The resident's personal body alarm was still attached to the chair. The nurse knocked on the bathroom door asking if the resident was okay? The resident replied with Yes, I'm fine and I'll be done in a minute when asked multiple times. The resident then said, Well, maybe you should come in here. Staff found the resident lying on his/her right side in front of the toilet with his/her hand and head just next to the call light pull string. The resident was alert and oriented x 3 and denied any pain, discomfort, or hitting his/her head. The resident's upper and lower ROM (range of motion) was within normal limits for resident. Staff assisted the resident into the wheelchair by this nurse and 3 staff members. When asked why he/she did not get assistance with going to the bathroom the reply was I didn't need any. When asked how he/she fell to the floor the reply was, I don't know, I just tumbled over. Vital Signs (VS)-blood pressure (B/P) ,[DATE] (normal 90-,[DATE]-90), temperature (temp) 97.9 (normal < 98.6 in geriatric population), respirations (resp) 18 (normal ,[DATE]), Heart Rate (HR) 58 (normal ,[DATE]), Oxygen Saturation (O2) 99% (normal ,[DATE]%) and Blood Sugar (BS) 107 (normal ,[DATE]). During further assessment, the resident stated he/she Must have bumped my head. Staff noted a small bruise and bump to the back of the resident's head, just below the hairline. PERRLA (pupils equal, round, reactive to light and accommodation) and grips equal. The resident denied N/V (nausea and vomiting) (PERRLA, grips and N/V were partial components of a thorough neurological assessment). Staff notified the physician by fax and left a message for the resident's DPOA (durable power of attorney) to contact the facility. The nurse's note, dated [DATE] at 6:45 AM, documented staff alerted this nurse that the resident's face was turning red as if choking. Upon entering the room the resident was lying on his/her back, in the bed coughing and gagging, with a red flushed face. After assisting the resident with elevating his/heard head, the resident coughed real hard and this nurse instructed him to cough up and spit out whatever he/she could. The resident stated I can't. and never spit anything out, but the coughing stopped and face began to be less flushed. VS then taken: BP ,[DATE], HR 72, Temp 97.4, Resp 24, O2 96%, PERRLA, Lungs sounds clear and equal on auscultation. The resident was confused and stated he/she was very tired, had no complaints of pain at this time with blood glucose of 89, will continue to monitor. The nurse's note, dated [DATE] at 7:15 AM, documented the resident lying on the left side with his/her head elevated. When asked, the resident was able to state name and what city we were in, but stated that this nurse was his/her mother and was unable to state his/her location. The resident's speech/conversation did not make sense and the resident complained of shortness of breath, denied any pain at this time, will continue to monitor. The nurse's noted, dated [DATE] at 7:43 AM, documented the resident with complaint of shortness of breath, chest pain, generalized pain, red flushed face, and very confused, stating, I just feel real, real bad. VS-BP ,[DATE], HR 82, temp 98.7, resp 24, O2 95%. Call placed to hospital to page on-call physician and call also placed to the DPOA and a voice message was left to return a call to the facility. The nurse's note, dated [DATE] at 8:20 AM, documented the resident transferred to the hospital via facility staff. On [DATE] at 5:15 PM, Administrative Staff A reported when he/she returned to the facility on Monday [DATE], staff told him/her the resident fell and went to the hospital, but he/she did not look into it any further at that time. Staff A reported that on Tuesday, [DATE] (3 days after the fall), during a department head meeting, staff discussed the fall in detail, for the first time, and it was at that time Staff A realized that an investigation into the fall was not completed and was necessary. Staff A reported, in his/her absence, it was the director of nursing's responsibility to report and investigate this accident, and in his/her absence the responsibility would fall on the assistant director of nursing. Staff A reported that the facility had just received word from the resident's family that the resident died in the hospital earlier today. On [DATE] at 5:50 PM, Administrative Nursing Staff B stated he/she feels he/she has a good understanding of what is a reportable accident to the State Agency and did not believe this was a reportable accident. Staff B was not aware of the accident until Sunday night, at the beginning of his/her shift at 6:00 PM, over 24 hours after the resident had fallen. Staff B confirmed the accident was not investigated or reported to the State Agency. The facility provided policy for Reporting Suspected Crimes, dated [DATE], documented the facility shall file a report with the State Agency and local law enforcement within a 24 hour period should suspicions of a crime against a resident be substantiated due to abuse, neglect, or misappropriation of resident property, as required by State and Federal law. The policy defines neglect as the failure of a caregiver to provide the goods or services that are necessary to maintain the health or safety of an elder. When staff suspect a crime has occurred against a resident they must report the incident to the state survey agency and local law enforcement. If the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately, but not later than 2 hours after forming the suspicion. The facility failed to investigate and report to the State agency this incident of alleged neglect for this resident, who suffered a fall with head injury that resulted in a subdural intracranial hematoma (an accumulation of blood in the subdural space) and the resident expired at the hospital.
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 31 residents, with 4 residents sampled for accidents. Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for 1 of the 4 sampled resident (#2) for falls and [MEDICATION NAME] (blood thinner medication) use. Findings included: - The physician order [REDACTED].#2 admitted to the facility on [DATE] with Diagnoses: [REDACTED]. by failing memory, confusion), difficulty walking and muscle weakness. The Admission MDS, dated [DATE], documented the resident BIMS (brief interview for mental status) score of 13, indicating cognitively intact; the resident required extensive assist of 2 staff for ADL's (activities of daily living); the resident is not steady, only able to stabilize with staff assistance and has no impairment in functional limitation of ROM (range of motion); a walker and wheelchair used for mobility; frequently incontinent of bowel and bladder, toileting program used; no falls noted; Antipsychotic, antidepressant, and anticoagulant medications used 7/7 days. The Admission CAA (care area assessment), dated 7/9/14, identified the following care areas: Falls - The resident has muscle weakness related to [MEDICAL CONDITION] and also received [MEDICATION NAME] (antidepressant) 50 mg (milligrams) daily, [MEDICATION NAME] (antidepressant) 30 mg TID (three times a day), [MEDICATION NAME] (antipsychotic) 0.5 mg TID that may cause drowsiness, lethargy that could promote falls. The care plan, last updated 7/2/14, lacked a care plan for falls or use of [MEDICATION NAME]. The physician order [REDACTED]. The Fall Risk Assessment, dated 6/26/14, documented a score of 17, a score of 10 or higher represents high fall risk. The record lacked any further fall assessment after the falls on 7/21/14, 7/23/14 or 7/28/14. The nursing order, dated 6/26/14,(before all three falls) documented bed sensor pad on at all times while in bed; chair alarm on at all times, every shift; floor sensor pad on at all times, every shift; tag alarm on at all times, every shift. This was not included on the care plan. The nursing order, dated 7/28/14 (after a fall), documented when the resident gets restless, please offer the resident to sit up front in a chair and offer a snack. On 8/12/14 at 4:12 PM, Direct Care Staff K reported the resident had at least two falls recently and uses the sit to stand for transfers. Staff K

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175416	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELMHAVEN WEST NURSING HOME	1315 S 15TH ST PARSONS, KS 67357

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 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) reported the interventions staff use to keep the resident from falling are a personal body alarm, chair alarm and floor alarm, they were in place since admission. Review of the nurse's notes revealed the resident experienced falls on 7/21/14, 7/23/14, and 7/28/14. On 8/12/14 at 11:38 AM, Direct Care Staff J reported the resident uses a sit to stand lift to transfer with 1 staff assist, has a tag alarm and chair alarm, bed low and a pad on the floor for fall preventions. On 8/12/14 at 1:15 PM, Licensed Nursing Staff E reported when a resident falls, the nurse should put new interventions in the care plan based on the issue that caused the fall. The resident fell 3 times recently. On 8/12/14 at 1:53 PM, Administrative Nursing Staff C reported the resident had several falls recently. Staff C confirmed that the resident's clinical record lacked a care plan for falls, or for increased bleed precautions for the use of [MEDICATION NAME]. Staff C confirmed that the need to care plan falls was identified on the admission CAA, dated 7/9/14, and not done. On 8/12/14 at 5:50 PM, Administrative Nursing Staff B confirmed the medical record for this resident lacked a fall care plan or [MEDICATION NAME] care plan for increased bleed risk. The facility failed to develop a comprehensive care plan for falls for this resident, identified as a fall risk, who suffered repeated falls or for [MEDICATION NAME] which increased bleeding risk.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 31 residents, with 4 residents sampled for accidents. Based on observation, interview and record review, the facility failed to review and revise care plans for 2 of the 4 sampled residents; #3 and #4, both identified as at risk for falls and suffererd falls. Findings included: - The physician order [REDACTED].#3 admitted to the facility on [DATE] with Diagnosis: [REDACTED]. The Care Plan, last updated 6/6/14 documented: Fall Risk - Encourage the resident to assume a standing position slowly; equip the resident a with device that monitors rising; the resident requires personal body alarm, chair sensor pad, and floor sensor alarm to monitor rising; give the resident verbal reminders not to ambulate/transfer without assistance; keep call light in reach at all times; keep personal items and frequently used items within reach; place the resident in a fall prevention program; provide proper, well-maintained footwear; provide toileting assistance every 2 hours, after meals and PRN; use Hoyer lift for all transfers for staff and resident safety; and up with assist x 2 Hoyer lift, wheelchair. The care plan lacked an update after the fall on 8/3/14 with a new intervention. The fall risk assessment, dated 6/12/14, documented score of 19, a score of 10 or higher represents high fall risk. The Annual MDS (minimum data set), dated 9/10/13, documented the resident BIMS (brief interview of mental status) score of 14, indicating cognitively intact; occasionally incontinent of bowel and bladder, no toileting program tried; one, non-injury fall noted; antipsychotic medications used 7/7 days. The CAA (care area assessment), dated 9/10/13, identified the following care areas: Falls - The resident has a [DIAGNOSES REDACTED]. The resident requires assistance with all ADL's and is unable to feed self at this time due to weakness and lack of coordination. The resident is on [MEDICATION NAME] (antianxiety) 0.25mg PRN (as needed) and [MEDICATION NAME] (antipsychotic) QHS (every night) which could contribute to lethargy, weakness and falls. The quarterly MDS, dated [DATE], documented the resident BIMS score of 13, indicating cognitively intact, with no behaviors noted; totally dependent of 2 staff for transfers and one staff for locomotion and toileting; frequently incontinent of bowel and bladder, no bladder training program tried; one non-injury fall noted; antipsychotic medication used 7/7 days. The nurse's order, dated 08/03/2014 at 5:27 PM, documented the intervention for the fall is for the resident to wear a personal body alarm at all times for safety. This was already an intervention on the care plan. On 8/12/14 at 1:53 PM, Administrative Nursing Staff C confirmed the care plan had not been updated with a new intervention after the resident's fall on 8/3/14. Staff C confirmed the intervention documented by the nurse after the fall in nursing orders was already in place on the care plan before the resident fell . On 8/12/14 at 5:50 PM, Administrative Nursing Staff B confirmed the intervention placed after the fall on 8/3/14 was already on the care plan, which had not been updated with a new intervention after the fall. The facility provided policy, not dated, documented ongoing regular assessments of resident's condition to see if their health status and/or interventions have changed. The charge nurse will update individualized care plan book with any new interventions as they arise and will notify MDS nurse of any changes. The facility failed to review and revise the care plan for this resident, identified as a fall risk, who suffered a fall. - The physician order [REDACTED].#4 re-admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. The Care Plan, last updated 6/16/14, documented the resident as a fall risk with the following interventions: bed sensor pad while in bed twice a day; encourage resident to assume a standing position slowly; encourage resident to use environmental devices such as hand grips, hand rails, etc.; floor alarm in place at all times when not in dining room; give resident verbal reminders not to ambulate/transfer without assistance; call light in reach; night light in room; non-skid socks; observe frequently and place in supervised area when out of bed; free of clutter; toileting every 2 hours and PRN (as needed); resident is not to be helped into wheelchair to leave the dining room until he/she can be taken to room by staff and transferred out of wheelchair; the resident to be set in lobby within site of the nurse's station while up; personal body alarm on at all times; and wander guard on at all times. The care plan lacked an update after the fall on 7/12/14 with a new intervention. Nursing Order, dated 7/14/14 documented a fall intervention to not leave the resident unattended in the TV room, or front lobby (this is the area by the nurse's station). This intervention was already on the care plan prior to the fall on 7/12/14. Admission MDS (minimum data set), dated 12/28/13, documented the resident BIMS (brief interview for mental status) score of 10, indicating moderately impaired cognition, with no behaviors present; requires supervision of 1 staff for transfers, ambulating, locomotion and toileting; always continent of bowel and bladder; with no falls noted. The CAA (care area assessment), dated 12/28/14, lacked identification of the fall care area. The Quarterly MDS, dated [DATE], documented the resident BIMS score of 8, indicating moderately impaired cognition; requires extensive assist of 1 staff for transfers, ambulating, locomotion and toileting; uses a walker and wheelchair for mobility; frequently incontinent of bowel and bladder, no toileting program used; 2 or more non-injury falls and 1 injury other than major fall noted; antianxiety and antidepressant medications used 7/7 days. Fall Risk Assessment, dated 6/20/14, documented score of 10, score of 10 or higher represents high risk for falls. On 8/12/14 at 1:53 PM, Administrative Nursing Staff C confirmed the care plan had not been updated with a new intervention after the resident's fall on 7/12/14. Staff C confirmed the intervention documented by the nurse after the fall in nursing orders was already in place on the care plan before the resident fell . On 8/12/14 at 5:50 PM, Administrative Nursing Staff B confirmed the intervention placed after the fall on 7/12/14 was already on the care plan, which had not been updated with a new intervention after the fall. The facility provided policy, not dated, documented ongoing regular assessments of resident's condition to see if their health status and/or interventions have changed. The charge nurse will update individualized care plan book with any new interventions as they arise and will notify MDS nurse of any changes. The facility failed to review and revise the care plan for this resident, identified at risk for falls, who suffered a fall.
F 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 31 residents, with 4 residents sampled for accidents. Based on interview and record review, the facility failed to initiate a care plan sufficient to meet the needs of this newly admitted resident prior to the completion of the first comprehensive assessment and care plan for resident #1, who suffered a fall with major injury. Findings included: - The physician order [REDACTED].#1 re-admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The nursing order (an order based on nursing judgment), dated 8/1/14, (at admission) documented use a personal body alarm at all times. The Admission Fall Risk Assessment, dated 8/1/14, documented a score of 15, a score of 10 or higher represents high fall risk. The resident had a physician's orders [REDACTED]. The lab for PT/INR ([MEDICATION NAME] time and international normalized ratio, a lab that [MEDICATION NAME] the bloods ability to clot), dated 8/4/14, documented the PT at 50.9, a high level (normal level = 9.9 to 11.9), indicating the blood took a longer time than usual to clot and dated 8/7/14 documented the PT at 28.9, a high level. On 8/12/14 at 11:38 AM, Direct Care Staff J reported the resident is 1 person assist with transfers and can be limited to extensive depending on the day. The resident has a personal body alarm on, but it does not do any good because he/she takes it off all the time. Staff were supposed to check regularly to see if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175416	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELMHAVEN WEST NURSING HOME	1315 S 15TH ST PARSONS, KS 67357

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 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) the alarm was on or not, usually it was not on. On 8/12/14 at 3:20 PM, Direct Care Staff L reported the resident had a personal body alarm, but tended to just take that off and set it on the bedside table, and sneak around in the room without staff knowing he/she was out of the chair or bed. On 8/12/14 at 1:05 PM, Direct Care Staff G reported the resident was knowledgeable of the call light and used it for help. Staff G reported the resident had a personal body alarm, but just took it off all the time. On 8/12/14 at 1:15 PM, Licensed Nursing Staff E reported the resident had a personal body alarm before the fall and was a fall risk due to weakness and increased confusion. On 8/12/14 at 1:53 PM, Administrative Nursing Staff C reported that the resident had fallen on 8/9/14 around 3:30 PM. The resident had taken off the personal body alarm and taken him/herself to the bathroom, where he/she suffered an un-witnessed fall and struck his/her head, per the resident's report. Staff reported that the resident was capable of using the call light and that it should remain in reach at all times for the resident. Staff confirmed that the nurse did not put a new intervention in place after this resident fell . Staff C reported that the expectation after a resident falls is that the nurses should assess the resident after a fall and place a new and appropriate intervention for the resident. On 8/12/14 at 5:15 PM, Administrative Staff A confirmed that it was well known by staff that the resident took off the personal body alarm, therefore it was not an appropriate intervention to keep the resident from falling. On 8/12/14 at 5:50 PM, Administrative Nursing Staff B confirmed the resident was capable of taking off the personal body alarm and frequently did so, making it not effective as an intervention to prevent falls. On 8/21/14 at 8:47 AM, Administrative Nursing Staff B reported the resident's cognition was intact and he/she was alert and oriented. Staff reported the resident was assist x 1 for ADL's (activities of daily living), but would not call for help. Staff B confirmed the resident had a history of [REDACTED]. Staff C was aware of this, but no other interventions were initiated to prevent falls. The facility provided policy for Care Plans, not dated, documented a temporary care plan will be completed at time of admission by the admitting nurse. A comprehensive care plan will be done consisting of kind of care, type of staff required, how often services are required, kind of equipment or supplies are needed .how the care plan will help the resident reach their goals. This plan of care will be done within 7 days of admission by the MDS nurse. The resident re-admitted to the facility on [DATE] and a care plan from a previous admission, dated 5/26/14, was re-initiated without being revised, no temporary care plan was used, and at the time of discharge to the hospital, 9 days after admission, no comprehensive care plan had been completed, per facility policy. The facility failed to initiate a care plan sufficient to meet the needs of this newly admitted resident prior to the completion of the first comprehensive assessment and care plan for this resident who suffered a fall with major injury.
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 31 residents, with 4 residents sampled for accidents. Based on observation, interview and record review, the facility failed to thoroughly assess the neurological condition of 2 of the 4 sampled residents. Resident #1, an alert and oriented resident, did not receive neurologic assessments after an un-witnessed fall with self-reported hit to head which resulted in a subdural intracranial hematoma (an accumulation of blood in the subdural space). This deficient practice placed resident #1 in immediate jeopardy, and the resident expired at the hospital. Resident #2, a confused resident, also did not receive neurologic assessments after 2 un-witnessed falls. Findings included: - The physician order [REDACTED].#1 re-admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The medical record lacked any MDS (minimum data set) data. The medical record lacked documentation of the resident's current level of cognition and ADL (activities of daily living) assistance. The care plan, last updated [DATE], identified the resident as a fall risk with the following interventions: assure the floor was free of glare, liquids, foreign objects; encourage the resident to assume a standing position slowly; encourage the resident to use environmental devices such as hand grips, hand rails, etc.; keep call light in reach at all times; keep personal items and frequently used items within reach; obtain a PT (physical therapy) consult for strength training, toning, positioning, transfer training, gait training, mobility devices, etc.; provide proper, well-maintained footwear; provide the resident an environment free of clutter; provide toileting assistance every 2 hours and PRN (as needed). The nurses note, dated [DATE] at 3:30 PM, documented this nurse went to the resident's room, the resident was not in his/her room and the wheelchair was found outside of the closed bathroom door. The resident's personal body alarm was still attached to the chair. Staff found the resident lying on his/her right side in front of the toilet. The resident was alert and oriented x 3 and denied any pain, discomfort, or hitting his/her head. This nurse and three other staff assisted the resident into the wheelchair. During further assessment, the resident stated he/she must have bumped his/her head. Staff noted a small bruise and bump to the back of the resident's head, just below the hairline. PERRLA (pupils equal, round, reactive to light and accommodation) and grips equal. The resident denied N/V (nausea and vomiting) (PERRLA, grips and N/V were partial components of a thorough neurological assessment). Staff notified the resident's physician by fax. The notification to the physician of the fall, dated [DATE] (a Saturday) at 5:37 PM (after normal business hours), sent by fax to the physician's office, documented the resident fell and hit his/her head with a bruise and bump on the back of the head just below the hairline. The nurse's note, on [DATE] at 9:12 PM, documented the resident was up in the lobby visiting with staff. The resident was in a good mood and joking with staff, alert and oriented per normal and propelled self in wheelchair around the lobby. The resident had no complaint of nausea, vomiting, or headache and ate a snack provided by the nurse. The nurse's note, dated [DATE] at 6:45 AM, documented staff alerted this nurse that the resident's face was turning red as if choking. Upon entering the room the resident was lying on his/her back, in the bed coughing and gagging, with a red flushed face. After assisting the resident with elevating his/her head, the resident coughed real hard and this nurse instructed him/her to cough up and spit out whatever he/she could. The resident stated he/she could not and never spit anything out, but the coughing stopped and his/her face began to be less flushed. The resident was confused and stated he/she was very tired, PERRLA. The nurse's note, dated [DATE] at 7:15 AM, documented the resident lying on the left side with his/her head elevated. When asked, the resident was able to state name and what city we were in, but stated that this nurse was his/her mother and was unable to state his/her location. The resident's speech/conversation did not make sense and the resident complained of shortness of breath, will continue to monitor. The nurse's noted, dated [DATE] at 7:43 AM, documented the resident with complaint of shortness of breath, chest pain, generalized pain, red flushed face, and very confused, and stated, he/she just feel real, real bad. The nurse called the hospital to page on-call physician. The nurse's note, dated [DATE] at 8:20 AM, documented the resident transferred to the hospital via facility staff. Review of the nurse's notes from the time of the fall, on [DATE] at 3:30 PM, to the time of transfer to the hospital, on [DATE] at 8:20 AM, revealed the record lacked any documentation of any thorough neurological assessments. The resident had a physician's orders [REDACTED]. The lab for PT/INR ([MEDICATION NAME] time and international normalized ratio, a lab that [MEDICATION NAME] the bloods ability to clot), dated [DATE], documented the PT at 50.9, a high level (normal level = 9.9 to 11.9), indicating the blood took a longer time than usual to clot and dated [DATE] documented the PT at 28.9, a high level. On [DATE] at 4:12 PM, Direct Care Staff K reported working on the day of the resident's fall. The nurse called me from another room [ROOM NUMBER] staff assisted the resident up off the floor. The resident said that when he/she stood up from the wheelchair he/she felt really woozy and fell . The resident was joking like normal after the fall and seemed ok. The last time I saw the resident that night was in the hall around 8:00 PM when he/she came up to the nurse's station to talk. On [DATE] at 3:20 PM, Direct Care Staff L reported working the day the resident fell and the nurse asked him/her to help after the fall. The resident was on the floor in the bathroom. Initially the resident said he/she didn't hit his/her head, but when the resident came up for dinner, said his/her head hurt. The nurse asked again if he/she hit his/her head and the resident said yes and you could see the big knot on the back of his/her head at that time. At about 8:00 PM, the resident sat in the hall by the doorway, then came to the nurse's station and talked with staff for a while. The resident acted normal, and joked with staff, never heard him/her complain about hurting at that time. On [DATE] at 11:45 AM, Direct Care Staff H reported on [DATE] at 6:39 AM, the resident was purple, it was like he/she was struggling to breath and the bed was flat. Staff H stepped into the hall and alerted the nurse and he/she came running. The nurse and staff H raised the head of the bed immediately, and sat him/her up. He/she began to breathe better so the nurse said he/she would sit with the resident and sent Staff H to go get other residents up. His/Her breathing was really labored and had a red face, on the forehead only, staff reported this to the nurse. Staff H returned to the resident's room about an hour later, around 8:00 AM, and noticed that the resident had vomited down the side of the bed, reported this to the nurse who said to clean the resident up, put him/her in the wheelchair, would need to take him/her to the hospital. Staff H reported the first time in the resident's room he/she was talking normal, but by the 3rd time he/she wasn't making any sense and had glassy eyes. Staff H had no idea the resident fell the day before, and was not told to check vital signs more frequently or do any increased visual checks on the resident. Staff H reported while

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175416	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELMHAVEN WEST NURSING HOME	1315 S 15TH ST PARSONS, KS 67357

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 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) dressing the resident, he/she noticed a fresh bruise on the resident's back, about 3 inches in size with numerous tiny, pinpoint size purple dots inside the bruise. On [DATE] at 1:53 PM, Administrative Nursing Staff C reported the resident fell on [DATE] around 3:30 PM. The resident took off the personal body alarm and took him/herself to the bathroom, where he/she suffered an un-witnessed fall and struck his/her head, per the resident's report. Staff C confirmed all post fall assessments should include initiation of neurologic assessments for any un-witnessed fall or if the resident hit their head. Staff confirmed this resident's record lacked any complete neurologic assessments after the fall, and reported the nurse that worked at the time of the fall should have initiated them. The neurologic assessment should have been done initially to include any change in level of consciousness, resident's orientation, pain, range of motion, grips of hands and status of pupils (PERRLA). Staff C confirmed that he/she worked the shift after the resident's fall, beginning at 6:00 PM, approximately 2 ? hours after the resident's fall, was aware of the fall and that the resident hit his/her head, and that Staff C also did not initiate neurologic checks on this resident. On [DATE] at 5:15 PM, Administrative Staff confirmed that neurologic assessments should have been initiated by the nurse at the time of the fall and were not done. Staff A confirmed that the next nurse that worked, should have realized that the neurologic assessments were not being done and started them, but did not. Staff A reported that the facility had just received word from the resident's family that the resident died in the hospital earlier today. On [DATE] at 5:50 PM, Administrative Nursing Staff B reported he/she was aware the resident hit his/her head in the fall and reported the expectation of the nurse was to complete a neurologic assessment immediately and then continued to complete them every 15 minutes 4 times, every 30 minutes 4 times, every hour 4 times, every 4 hours 4 times, then each shift 2 times and confirmed this was not done. The local emergency room Handoff Communication Form, dated [DATE] at 10:22 AM, and provided by the hospital, documented the resident arrived at the emergency department on [DATE] at 8:45 AM with chief complaint of fall injury and vomiting and admitting [DIAGNOSES REDACTED]. The resident had a recent change in mental status, some significant bruising on his/her left neck and upper back. The patient was alert but unable to answer questions appropriately. The local hospital discharge summary, dated [DATE] at 10:39 AM, provided by hospital staff, documented on [DATE] at 10:22 AM, the resident transferred to a regional hospital for higher level of care, and the resident's condition was critical. The local hospital Diagnostic Imaging Report, dated [DATE] at 9:39 AM, provided by the hospital, for CT of head without contrast documented hemorrhage with bleeding. On [DATE] at 12:19 PM, Physician Consultant M reported that he/she received the resident in the local Emergency Department on [DATE] a little after 8:00 AM and that the resident had arrived by private vehicle with complaint of chest pain and shortness of breath with vomiting. Physician M reported it was obvious the resident had altered mental status due to when asked his/her name, he/she was unable to state and answered cat to what year it was. Most other questions were answered I don't know, and the resident was unable to follow simple commands. Physician M reported the resident was suffering from [MEDICAL CONDITION] (a disturbance of the comprehension and expression of language caused by dysfunction in the brain) due to a left sided bleed which would affect speech and the ability to properly respond to questions that he/she most probably understood. Physician M reported the resident was clearly obtunded (mental [MEDICATION NAME] with mild to moderate reduction in alertness and a diminished sensation of pain) at that time and presented with a large bruise on the left scapula (shoulder blade) and also midline in the spine area. Physician M reported that he/she felt like the injuries confirmed by the CT were a result of the fall. Physician M reported the clinical reason for a subdural bleed is typically a result of trauma, and the patient was on anticoagulant therapy, which is known to increase the risk of delayed bleed after a fall and trauma as well as the finding of significant bruising in the cervical and [MEDICATION NAME] areas. The resident's status was critical at the time of discharge. The regional hospital Intensive Care Unit patient record, provided by the hospital, documented the following: 1.) Neurological Assessment, dated [DATE] at 11:47 AM, Level of Conscious - The patient was unresponsive; had a head injury, a recent fall on [DATE]. 2.) Emergency Department Faculty Note, dated [DATE] at 11:39 AM, documented the patient was emergently intubated (placement of a flexible tube into windpipe to maintain an airway for breathing) secondary to altered mentation (a state of confusion) and decreased level of consciousness (a measure of arousal other than normal. 3.) The patient admitted to the Intensive Care Unit at the regional hospital. Physician N evaluated the patient around 4:15 PM, reporting the patient was in [DIAGNOSES REDACTED] (a [MEDICAL CONDITION] that lasts 30 minutes or longer), and was seizing. Upon request, the facility failed to provide a policy on assessment of a resident after a fall or change of condition. The facility failed to provide thorough neurologic assessments for resident #1 after a fall with head injury, which placed him/her in immediate Jeopardy. The resident experienced a significant change in condition, and was sent to the emergency room with a subdural hematoma. The resident expired at the hospital. The facility abated the immediate jeopardy, on [DATE] at 8:00 PM by initiating the following: The nurses and certified nurse's aides working tonight, [DATE] and Thursday [DATE] were being immediately trained by Administrative Nursing Staff B on the information listed below. Administrative Staff A, Administrative Nursing Staff B, and Administrative Nursing Staff C will meet tonight with the licensed nurses to make sure they all understand what is listed below. It has already been posted to nursing staff by Administrative Nursing Staff B that he/she is to be informed of any fall. All un-witnessed falls or when there is possible head trauma will have neuro checks done. Neuro checks will include checking pupils to see if equal and reactive to light, level of consciousness, facial muscle movement, upper extremity movement/grasps, lower extremity movement, speech, any pain and the ability to respond appropriately, any complaints of dizziness, headache, nausea/vomiting or [MEDICAL CONDITION]. The frequency of the neuro checks will be done as follows: group 1 every 15 minutes times 4, group 2 every 30 minutes times 4, group 3 every 1 hour times 4, group 4 every 2 hours times 4, group 5 every 4 hours times 4, group 6 every shift times 4 and group 7 every shift times 1. See attached sheet regarding neuro checks. If any of the neuro checks are abnormal, that will be reason to send the resident to ER for evaluation. Routine assessment for falls other than possible head injury will include head to toe body assessment, review of medications, full set of vital signs, neuro checks if warranted, assess level of consciousness and orientation times 3 plus a pain assessment with asking resident specifically if any headache. Certified nursing staff will be instructed to observe resident closely for any change in level of consciousness and to notify the nurse in charge. Dr. will be paged for any major injury (neuro checks abnormal, possibility of fracture, sutures needed) any time of the week to inform him of their condition and the family Is notified. If a resident has a fall with no injury the family will be notified and the Dr. will be faxed. When Administrative Nursing Staff B was off, Administrative Nursing Staff C would be notified and follows this protocol. All licensed nurses would be re-trained by reviewing the current [MEDICATION NAME] policy on what needs to be observed when a resident is on anti-coagulant therapy. Licensed Nursing Staff D and Administrative Nursing Staff C will be counseled about the severity of not initiating proper assessments after falls and the KSBN (Kansas State Board of Nursing) will be notified [DATE]. This is being implemented immediately and all licensed nurses are being in-serviced and would be done by [DATE] at 8:00 PM. This immediate jeopardy was abated, on [DATE] at 8:00 PM; however the deficiency remained at a scope and severity of a G. - The physician order [REDACTED].#2 admitted to the facility on [DATE] with Diagnosis: [REDACTED]. by failing memory, confusion), difficulty walking and muscle weakness. The care plan, last updated [DATE], lacked a care plan for falls. The Admission MDS, dated [DATE], documented the resident BIMS (brief interview for mental status) score of 13, indicating cognitively intact; the resident required extensive assist of 2 staff for ADL's (activities of daily living); the resident is not steady, only able to stabilize with staff assistance and has no impairment in functional limitation of ROM (range of motion); a walker and wheelchair used for mobility; frequently incontinent of bowel and bladder, toileting program used; No pain medications used and no pain noted; no falls noted; Antipsychotic, antidepressant, and anticoagulant medications used ,[DATE] days. The Admission CAA (care area assessment), dated [DATE], identified the following care areas: ADL's - The resident has a [DIAGNOSES REDACTED]. The resident needs extensive assistance with ADL ' s related to [MEDICAL CONDITION], and muscle weakness. Falls - The resident has muscle weakness related to [MEDICAL CONDITION] and also takes [MEDICATION NAME] 50 mg (milligrams) daily, [MEDICATION NAME] 30 mg TID (three times a day), [MEDICATION NAME] 0.5 mg TID that may cause drowsiness, lethargy that could promote falls. The Fall Risk Assessment, dated [DATE], documented a score of 17, a score of 10 or higher represents high fall risk. The record lacks any further fall assessment after the falls on [DATE], [DATE] or [DATE]. The nursing orders, dated [DATE], (before all three falls) documented a bed sensor pad on at all times while in bed; chair alarm on at all times, every shift; floor sensor pad on at all times, every shift; tag alarm on at all times, every shift. The nurse's note, dated [DATE] at 4:08 PM, documented the CNA's reported that they found the resident on the floor. Staff went in the resident's room to find the resident sitting on the floor between the bed and the wheelchair with legs stretched out and left arm resting on the wheelchair seat. The resident denies pain and hitting his/her head, range of motion x 4 without pain or difficulty, vital signs stable, PERRLA (pupils equal, round, reactive to light and accommodation).The resident assisted back into wheelchair, no bruising or redness noted. The resident stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175416	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELMHAVEN WEST NURSING HOME	1315 S 15TH ST PARSONS, KS 67357

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 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 4) he/she was attempting to get up to go do the chores and just sat on the floor then waited for help. No alarms sounded due to the tag alarm had been taken off, the bed alarm had been turned off and the floor alarm was not in place. Staff spoke with CNA's and informed them to check all alarms when doing change of shift bed check. The nurse's note, dated [DATE] at 6:49 AM, documented the resident lying in bed, woke to verbal stimuli and denies pain. Multiple bruises noted to the residents right arm and one on the right abdomen, +1 [MEDICAL CONDITION] to LLE (lower left extremities) and ROM (range of motion)WNL (within normal limits) for the resident. The nurse's note, dated [DATE] at 4:16 PM documented housekeeping staff responded to the residents' alarms sounding and found the resident on the floor and waited for nursing staff to arrive. The resident found sitting on buttocks with legs out in front and wheelchair behind, wanting staff to help him/her up. The resident denies pain and states he/she needs to get back to the fields to work. The resident assisted to wheelchair, ROM WNL no shortening or rotation of extremities noted. The resident refused to allow VS (vital signs) to be assessed due to going to fields to work and his/her dad would be very upset when he/she came home with the chores not done. Staff attempted to explain to the resident that chores were already done and the resident replied Now just shut up, you don't know what you're talking about. Staff was unable to assess the resident for redness or bruising at this time due to the resident's frustration. Review of the medical record reveals the record lacked any neurological assessments after 2 of 3 un-witnessed falls for this confused resident. On [DATE] at 11:59 AM, the resident's tab alarm sounded, audible in hall from the room, the resident was transferring self from the wheelchair to the toilet. Three staff responded to the alarm, however, the resident was already sitting on the toilet. On [DATE] at 11:45 AM, Direct Care Staff H reported the resident has had a few falls recently, used to try and transfer self all the time and fell a lot doing it. Now, the resident accepts help more. Staff H reported the resident used a tag, chair, and floor alarm. The tag and chair alarm are used whenever in the wheelchair and all three are for whenever he/she is in bed or in the recliner, and keep the bed low. You have to watch the resident's posture in the recliner, to keep from tipping out. The resident takes the tag alarm off all the time, is sneaky. Staff H reported the facility have not figured out how to put it on so the resident cannot remove it. On [DATE] at 1:15 PM, Licensed Nursing Staff E reported that whenever there is a fall, the nurse should do a full assessment of the resident, head to toe, check vital signs, range of motion, mental status, and look for bumps and bruises. If resident hit their head, or if you aren't sure if they did, you should start the neurologic checks immediately and repeat them every 15 minutes 4 times, every half hour 4 times, every hour 4 times, every 2 hours 4 times, every 4 hours 4 times, every shift 4 times then once the last day. Then notify the family and physician by phone, you need to talk to both of them. The neurologic checks are done in the computer, and can be found under observation tab or they can be done on paper and scanned into the computer, then they would be found under the resident documents. Staff confirmed that the resident's falls on [DATE] and [DATE] were un-witnessed and neurologic assessments were not done. Staff E confirmed the resident was too confused to accurately recall if he/she had hit his/her head and neurologic assessments should have been initiated for both falls. On [DATE] at 5:15 PM, Administrative Staff A confirmed that the resident is confused. Staff A confirmed that the resident has had 3 recent falls, 2 of them were un-witnessed and that neurologic assessments should have been initiated by the nurse at the time of the fall and that had not been done. On [DATE] at 5:50 PM, Administrative Nursing Staff B confirmed the resident is confused and reports that when a resident falls, if they are not witnessed or if they know the resident has hit their head the expectation of the nurse was to have completed a neurologic assessment immediately and then to have continued to completed them every 15 minutes 4 times, every 30 minutes 4 times, every hour 4 times, every 4 hours 4 times, then each shift 2 times and confirmed this was not done. Staff B confirmed that this had not been done for 2 of the 3 un-witnessed falls for this resident. On [DATE] at 1:30 PM, Administrative Staff A confirmed that the facility lacked a policy on assessment of a resident after a fall or change of condition. The facility failed to provide thorough neurologic assessments for 2 out of 3 un-witnessed falls for this confused resident.
F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 31 residents, with 4 residents sampled for accidents. Based on interview and record review, the facility failed to develop and implement appropriate interventions to prevent falls for 2 (#1 and #2) of the 4 residents reviewed for accidents: Resident #1, whose fall resulted in hospitalization for a subdural intracranial hematoma (an accumulation of blood in the subdural space) and resident #2 who experienced repeated falls. Findings included: - The physician order [REDACTED].#1 re-admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The medical record lacked any MDS (minimum data set) data. The medical record lacked current assessments or documentation of the resident ' s current level of cognition and ADL (activities of daily living) assistance. The care plan, last updated 5/26/14 and re-initiated for re-admission on 8/1/14, identified the resident as a fall risk with the following interventions: assure the floor was free of glare, liquids, foreign objects; encourage the resident to assume a standing position slowly; encourage the resident to use environmental devices such as hand grips, hand rails, etc.; keep call light in reach at all times; keep personal items and frequently used items within reach; obtain a PT (physical therapy) consult for strength training, toning, positioning, transfer training, gait training, mobility devices, etc.; provide proper, well-maintained footwear; provide resident an environment free of clutter; provide toileting assistance every 2 hours and PRN (as needed). The Nursing Order (an order placed on the medical record per nursing judgment), dated 8/1/14, (at admission) documented personal body alarm on at all times, every shift and dated 8/9/14, (after the fall) documented chair alarm on at all times, every shift. The nurses note, dated 8/9/14 at 3:30 PM, documented this nurse went to the resident's room, the resident was not in his/her room and the wheelchair was found outside of the closed bathroom door. The resident's personal body alarm was still attached to the chair. Staff found the resident lying on his/her right side in front of the toilet. The resident was alert and oriented x 3 and denied any pain, discomfort, or hitting his/her head. Staff assisted the resident into the wheelchair by this nurse and 3 staff members. During further assessment, the resident stated he/she must have bumped his/her head. Staff noted a small bruise and bump to the back of the resident's head, just below the hairline. The notification to physician of the fall, dated 8/9/14 (a Saturday) at 5:37 PM (after normal business hours), sent by fax to the physician's office, documented the resident fell and hit head with a bruise and bump on the back of the head just below the hairline. The nurse's note, dated 8/10/14 at 6:45 AM, documented staff alerted this nurse that the resident's face was turning red as if choking. Upon entering the room the resident was lying on his/her back, in the bed coughing and gagging, with a red flushed face. After assisting the resident with elevating his/heard head, the resident coughed real hard and this nurse instructed him to cough up and spit out whatever he/she could. The resident stated I can't. and never spit anything out, but the coughing stopped and face began to be less flushed. The resident was confused and stated he/she was very tired. The nurse's note, dated 8/10/14 at 7:15 AM, documented the resident lying on the left side with his/her head elevated. When asked, the resident was able to state name and what city we were in, but stated that this nurse was his/her mother and was unable to state his/her location. The resident's speech/conversation did not make sense and the resident complained of shortness of breath, denied any pain at this time, will continue to monitor. The nurse's noted, dated 8/10/14 at 7:43 AM, documented the resident with complaint of shortness of breath, chest pain, generalized pain, red flushed face, and very confused, stated, he/she just felt real, real bad. The nurse placed a call to the on call physician. The nurse's note, dated 8/10/14 at 8:20 AM, documented the resident transferred to the hospital via facility staff. The Admission Fall Risk Assessment, dated 8/1/14, documented score of 15, score of 10 or higher represents high fall risk. On 8/12/14 at 4:12 PM, Direct Care Staff K reported working on the day of the resident's fall. The nurse called him/her from another room and said the resident was on the floor, 4 staff assisted him/her up off the floor. The nurse took the residents' vitals. The resident said that when he/she stood up from the wheelchair he/she felt really woozy and fell . The resident was to have a personal body alarm clipped on, but always unclipped it so we could not hear him/her. Staff was supposed to check regularly throughout the shift to see if it remained attached. On 8/12/14 at 3:20 PM, Direct Care Staff L reported working the day the resident fell , and the resident was on the floor in the bathroom, said he/she didn't know how long he/she had been there, had a personal body alarm, but tended to take it off. The resident would place the alarm on the bedside table, and sneak around in the room without staff knowing he/she was out of the chair or bed. Initially the resident said he/she didn't hit his/her head, but when the resident came up for dinner, said his/her head hurt. The nurse asked again if he/she hit his/her head and the resident said yes and you could see the big knot on the back of his/her head at that time. On 8/12/14 at 11:45 AM, Direct Care Staff H reported the resident had a personal body alarm before the fall. Staff H reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175416	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELMHAVEN WEST NURSING HOME	1315 S 15TH ST PARSONS, KS 67357

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 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) the tag alarm was not on the resident, it was lying on the bedside table, not attached to the resident. The call light was not in reach, it was slung up over and behind the headboard. On 8/12/14 at 1:53 PM, Administrative Nursing Staff C reported that the resident fell on [DATE] around 3:30 PM. The resident took off the personal body alarm and took him/herself to the bathroom, where he/she suffered an un-witnessed fall and struck his/her head, per the resident's report. On 8/12/14 at 5:50 PM, Administrative Nursing Staff B confirmed the resident was capable of taking off the tag alarm and frequently did so, making it not effective as an intervention to prevent falls and no other intervention was implemented prior to this resident's fall. On 8/21/14 at 8:47 AM, Administrative Nursing Staff B reported the resident's cognition was intact and he/she was alert and oriented, the facility had not done all of the admission assessments yet that would give a BIMS (brief interview for mental status) score. The resident was assist x 1 for ADL's (activities of daily living), but would not call for help from the staff. The resident had a history of [REDACTED]. Staff was aware of this, but no other interventions were initiated to prevent falls. The local emergency room Handoff Communication Form, dated 8/13/14 at 10:22 AM, and provided by the hospital, documented the resident arrived at the emergency department on 8/10/14 at 8:45 AM with chief complaint of fall injury and vomiting and admitting [DIAGNOSES REDACTED]. The facility provided policy for Fall Prevention, dated 2013, documented the charge nurse on duty at the time of the fall must investigate the fall for possible cause and must initiate one or more interventions . to aid in preventing further falls immediately. The facility failed to implement appropriate interventions to prevent the resident from falling, resulting in a fall with injury, subdural intracranial hematoma (an accumulation of blood in the subdural space). - The physician order [REDACTED].#2 admitted to the facility on [DATE] with Diagnosis: [REDACTED]. by failing memory, confusion), difficulty walking and muscle weakness. The care plan, last updated 7/2/14, lacked a care plan for falls. The Admission MDS, dated [DATE], documented the resident BIMS (brief interview for mental status) score of 13, indicating cognitively intact; the resident required extensive assist of 2 staff for ADL's (activities of daily living); the resident is not steady, only able to stabilize with staff assistance and has no impairment in functional limitation of ROM (range of motion); a walker and wheelchair used for mobility; frequently incontinent of bowel and bladder, toileting program used; No pain medications used and no pain noted; no falls noted; Antipsychotic, antidepressant, and anticoagulant medications used 7/7 days. The Admission CAA (care area assessment), dated 7/9/14, identified the following care areas: ADL's - The resident has a [DIAGNOSES REDACTED]. The resident needs extensive assistance with ADL's related to Parkinson's, and muscle weakness. Falls - The resident has muscle weakness related to Parkinson's disease and also takes Zoloft 50 mg (milligrams) daily, Cymbalta 30 mg TID (three times a day), Haloperidol 0.5 mg TID that may cause drowsiness, lethargy that could promote falls. The Fall Risk Assessment, dated 6/26/14, documented a score of 17, a score of 10 or higher represents high fall risk. The record lacks any further fall assessment after the falls on 7/21/14, 7/23/14 or 7/28/14. The nursing orders, dated 6/26/14, (before all three falls) documented a bed sensor pad on at all times while in bed; chair alarm on at all times, every shift; floor sensor pad on at all times, every shift; tag alarm on at all times, every shift. The nurse's note, dated 07/21/2014 at 4:08 PM, documented the CNA's reported that they found the resident on the floor. Staff went in the resident's room to find the resident sitting on the floor between the bed and the wheelchair with legs stretched out and left arm resting on the wheelchair seat. The resident denies pain and hitting his/her head, range of motion x 4 without pain or difficulty, vital signs stable, PERRLA (pupils equal, round, reactive to light and accommodation).The resident assisted back into wheelchair, no bruising or redness noted. The resident stated he/she was attempting to get up to go do the chores and just sat on the floor then waited for help. No alarms sounded due to the tag alarm had been taken off, the bed alarm had been turned off and the floor alarm was not in place. Staff spoke with CNA's and informed them to check all alarms when doing change of shift bed check. The nurse's note, dated 07/22/2014 at 6:49 AM, documented the resident lying in bed, woke to verbal stimuli and denies pain. Multiple bruises noted to the residents right arm and one on the right abdomen, +1 pitting edema to LLE (lower left extremities) and ROM (range of motion) WNL (within normal limits) for the resident. The nurse's note, dated 07/28/2014 at 4:16 PM documented housekeeping staff responded to the residents' alarms sounding and found the resident on the floor and waited for nursing staff to arrive. The resident found sitting on buttocks with legs out in front and wheelchair behind, wanting staff to help him/her up. The resident denies pain and states he/she needs to get back to the fields to work. The resident assisted to wheelchair, ROM WNL no shortening or rotation of extremities noted. The resident refused to allow VS (vital signs) to be assessed due to going to fields to work and his/her dad would be very upset when he/she came home with the chores not done. Staff attempted to explain to the resident that chores were already done and the resident replied Now just shut up, you don't know what you're talking about. Staff was unable to assess the resident for redness or bruising at this time due to the resident's frustration. Review of the medical record reveals the record lacked any neurological assessments after 2 of 3 un-witnessed falls for this confused resident. On 8/12/14 at 11:59 AM, the resident's tab alarm sounded, audible in hall from the room, the resident was transferring self from the wheelchair to the toilet. Three staff responded to the alarm, however, the resident was already sitting on the toilet. On 8/12/14 at 11:45 AM, Direct Care Staff H reported the resident has had a few falls recently, used to try and transfer self all the time and fell a lot doing it. Now, the resident accepts help more. Staff H reported the resident used a tag, chair, and floor alarm. The tag and chair alarm are used whenever in the wheelchair and all three are for whenever he/she is in bed or in the recliner, and keep the bed low. You have to watch the resident's posture in the recliner, to keep from tipping out. The resident takes the tag alarm off all the time, is sneaky. Staff H reported the facility have not figured out how to put it on so the resident cannot remove it. On 8/12/14 at 1:15 PM, Licensed Nursing Staff E reported that whenever there is a fall, the nurse should do a full assessment of the resident, head to toe, check vital signs, range of motion, mental status, and look for bumps and bruises. If resident hit their head, or if you aren't sure if they did, you should start the neurologic checks immediately and repeat them every 15 minutes 4 times, every half hour 4 times, every hour 4 times, every 2 hours 4 times, every 4 hours 4 times, every shift 4 times then once the last day. Then notify the family and physician by phone, you need to talk to both of them. The neurologic checks are done in the computer, and can be found under observation tab or they can be done on paper and scanned into the computer, then they would be found under the resident documents. The nurse should put new interventions based on the issue that caused the fall. It would be put under care plans in the computer, then print it and use it to show the staff that there is a new intervention and put that sheet in the DON Communication Book for all the staff to see. All falls should have new interventions that are appropriate and a sheet put in the communication book. The most current care plan for a resident is the electronic record, it is the only one, and the facility does not keep a paper copy. Staff E reported the resident fell 3 times recently. Staff added alarms and when restless staff are to bring him/her to the nurse station and offer a snack. Staff confirmed that the resident ' s falls on 7/21/14 and 7/28/14 were un-witnessed and neurologic assessments were not done. Staff E confirmed the resident was too confused to accurately recall if he/she had hit his/her head and neurologic assessments should have been initiated for both falls. On 8/12/14 at 5:15 PM, Administrative Staff A confirmed that the resident is confused. Staff A confirmed that the resident has had 3 recent falls, 2 of them were un-witnessed and that neurologic assessments should have been initiated by the nurse at the time of the fall and that had not been done. On 8/12/14 at 5:50 PM, Administrative Nursing Staff B confirmed the resident is confused and reports that when a resident falls, if they are not witnessed or if they know the resident has hit their head the expectation of the nurse was to have completed a neurologic assessment immediately and then to have continued to completed them every 15 minutes 4 times, every 30 minutes 4 times, every hour 4 times, every 4 hours 4 times, then each shift 2 times and confirmed this was not done. Staff B confirmed that this had not been done for 2 of the 3 un-witnessed falls for this resident. On 8/14/14 at 1:30 PM, Administrative Staff A confirmed that the facility lacked a policy on assessment of a resident after a fall or change of condition. The facility failed to provide thorough neurologic assessments for 2 out of 3 un-witnessed falls for this confused resident.