STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087075	A. BUILDING: _____ B. WING _____	R 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OXFORD GRAND	3051 N PARKDALE CIRCLE WICHITA, KS 67205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	INITIAL COMMENTS The following citations represent the findings of a revisit for correction order 18-131 of the above named assisted living facility conducted on 9/12/18 and 9/13/18.	{S 000}		
{S3155} SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 78 residents. The sample included 7 residents with bed mobility assistive devices. Based on observation, record review and interview the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of each resident and were in accordance with the functional capacity screening and negotiated service agreement for 7 of 7 sampled residents (#1190, #1191, #1198, #1216, #1510, #1515 and #1523) in regards to bed rail(s) or attached assistive device(s). Findings included:	{S3155}		

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

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{S3155}	Continued From page 1 - Review of the resident roster provided by the facility on 9/12/18 revealed 12 residents used a bed rail or assistive device which included resident #1515. Record review revealed an admission date of 8/16/18 for resident #1515 with diagnosis of dementia. The admission functional capacity screen dated 8/16/18 identified the resident with short-term and long-term deficits, memory recall deficit and impaired decision making. He/she needed physical assistance with bathing, dressing, toileting and identified as fall risk. The record included a side rail rationale screen which included 10 screening questions as follows: 1. Is the resident ambulatory 2. Is the resident comatose, semi-comatose, obtunded or has fluctuations in level of conscious 3. Does the resident have alteration in safety awareness due to cognitive decline 4. Does the resident have a history of falls 5. Has the resident demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed 6. Does the resident have difficulty with balance or poor trunk control 7. Does the resident have difficulty with postural hypotension 8. Is the resident on any medications which would require increased safety precautions 9. Is the resident currently using the side rail for position or support 10. Has the resident expressed a desire to have side rails raised while in bed Licensed nurse D completed the screening on 9/6/18 with yes answers to all questions except	{S3155}		

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{S3155}	Continued From page 2 #2 and #4. The screening identified side rails were indicated and serve as an enabler to promote independence. The screening did not include any information about the type of bed rail/assistive device to be used, the safety of the device or the gaps between the different areas of the rail to ensure the device was not an entrapment risk. The negotiated service agreement dated (NSA) 8/16/18 indicated the resident was not oriented to time or place and cannot remember or use information with frequently poor judgement and needed supervision. The NSA directed staff the resident required 1 assist for mobility with occasional stand-by assist with ambulating and transfers. The NSA failed to include the use of a bed rail/assistive device. The health service plan (HSP) dated 8/16/18 indicated the resident needed physical assistance with grooming, dressing, toileting of 1 staff. The resident needed verbal cueing to use a walker/cane, 1 staff assist with wheelchair for distance and stand-by assistance with transfers. The HSP failed to include any information about the use of a bed rail/assistive device. The section related to potential risks identified fall risk/unsteadiness, impaired vision and decision making. Observation on 9/12/18 at 1:12 PM with direct care staff F revealed an assistive device made out of plastic tubing (like used for plumbing) which was located on the outer side of the bed with the bed up against the wall on the other side. The gap between the 2 upright portions of the device was approximately 10 inches wide. When the surveyor applied minimal pulling force the assistive device freely moved out from under the	{S3155}		

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{S3155}	Continued From page 3 mattress with such suddenness to cause a TV tray type table beside it to fall over. The base of the device which was inserted between the mattress and the box spring was about 12 inches in depth. Direct care staff F put the device back into position and he/she was also able to move the device with a minimal pulling force out from under the mattress creating a greater fall risk. Observation and interview on 9/12/18 at 1:20 PM with maintenance director H confirmed the assistive device needed to be secured to the bed with straps or something to prevent the device from becoming dislodged. He/she removed the device at this time. The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident and were in accordance with the functional capacity screening and negotiated service agreement regarding the use of bed rail(s)/assistive device(s).	{S3155}		

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{S3155}	Continued From page 4 - Review of the resident roster provided by the facility on 9/12/18 revealed 12 residents used a bed rail or assistive device which did not include resident #1523 but observation on 9/12/18 revealed full bed rails on the bed. Record review revealed resident #1523 admitted to the facility on 11/1/13. He/she had the following diagnoses: dementia and Parkinson's. The significant change assessment functional capacity screen (FCS) dated 5/23/18 identified the resident with short-term and long-term memory deficit, memory/recall deficit and impaired decision making. The FCS indicated the resident was unable to perform any activities of daily living (ADLs) (bathing, dressing, toileting, transfers, walking/mobility). He/she had risk for fall/unsteadiness and used a wheelchair. The record included a side rail rationale screen which included 10 screening questions as follows: 1. Is the resident ambulatory 2. Is the resident comatose, semi-comatose, obtunded or has fluctuations in level of conscious 3. Does the resident have alteration in safety awareness due to cognitive decline 4. Does the resident have a history of falls 5. Has the resident demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed 6. Does the resident have difficulty with balance or poor trunk control 7. Does the resident have difficulty with postural hypotension 8. Is the resident on any medications which would require increased safety precautions 9. Is the resident currently using the side rail for position or support 10. Has the resident expressed a desire to have	{S3155}		

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{S3155}	Continued From page 5 side rails raised while in bed Licensed nurse D completed the screening on 9/6/18 with yes answers to all questions except #1, #2, #7 and #10. The screening identified side rails were not indicated at this time. The screening did not include any information about the presence of rails still attached to the bed or directions not to use. The screening failed to include any information about the safety of the device or the gaps between the different areas of the rail to ensure the device was not an entrapment risk. The negotiated service agreement (NSA) dated 5/23/18 indicated the resident required extended services for all ADLs. The NSA lacked information about the resident's fall risk and the presence of bed rails. The health service plan (HSP) dated 5/23/18 indicated the resident needed physical assistance for all ADLs, used a wheelchair and walker with 1 staff assistance for routine transfers. He/she had a history of falls with 23 incidents listed, had impaired decision making and lacked any information about bed rails attached to the bed. Observation on 9/12/18 at 11:40 AM revealed the resident sat in a high back wheelchair at the dining room table. Observation of the resident's room revealed a hospital style bed with 1 side against the wall and a full bed rail on the outer side of the bed in the down position. The gaps between each section of the rail appeared to be greater than 5 inches, the gap between the end of the rail and the foot of the bed appeared to be greater than 12 inches and from the top of the rail to the head of the bed frame greater than 16 inches.	{S3155}		

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{S3155}	Continued From page 6 Observation on 9/12/18 at 1:05 PM with direct care staff F revealed he/she pulled the rail up with only mild resistance to the full upright position. He/she then demonstrated how he/she positioned the rail with only the top half of the rail in the upright position. At that time, it was discovered the bed rail had a single plastic narrow tie down strap attached in the center which had broken when direct care staff F raised the rail. Interview on 9/12/18 at 12:25 PM with certified medication aide G revealed the resident used the bed rails to help get up and to hold onto during cares. He/she indicated the rails were still in use and in the mornings, both ends of the rail would be in the upright position but during the day if the resident laid down he/she would only raise the top portion of the rail. Interview on 9/12/18 at 12:26 PM with direct care staff F revealed he/she put the bed rail up at the top portion but he/she would usually find it with both rails up in the morning. He/she indicated the resident fidgeted in bed, would stick his/her leg out or over the rail and had scooted to the foot of the bed to attempt to get out of bed. Interview on 9/12/18 at 1:20 PM with maintenance director H confirmed he/she had recently attached the narrow plastic tie strap to the center of the rail and bed as a means to discourage staff from using the rail. He/she examined the bed and determined the rails could be removed completely. Interview with licensed nurse D on 9/12/18 at 1:30 PM confirmed he/she had determined the resident did not need the bed rails. He/she did not know if staff received training on not to use the	{S3155}		

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{S3155}	Continued From page 7 rails. Interview with administrative nurse E on 9/12/18 at 11:00 AM revealed all residents with bed rails were screened for use of the bed rail and if the rail could not be removed the rail was tied down. The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident and in accordance with the functional capacity screening and negotiated service agreement regarding a bed rail/bed assistive device attached to the bed. - Record review for resident #1190 revealed an admission date of 12/2/16. He/she had the following diagnoses: dementia, hypertension, congestive heart failure, atrial fibrillation, chronic obstructive pulmonary disease and asthma. The annual functional capacity screen (FCS) dated 6/4/18 indicated the resident needed	{S3155}		

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{S3155}	Continued From page 8	{S3155}		

physical assistance with dressing and supervision with transfers, walking and mobility. The FCS indicated the resident used an assistive device of a walker but did not include the use of bed assistive devices.

The record included a side rail rationale screen which included 10 screening questions as follows:
1. Is the resident ambulatory
2. Is the resident comatose, semi-comatose, obtunded or has fluctuations in level of conscious
3. Does the resident have alteration in safety awareness due to cognitive decline
4. Does the resident have a history of falls
5. Has the resident demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed
6. Does the resident have difficulty with balance or poor trunk control
7. Does the resident have difficulty with postural hypotension
8. Is the resident on any medications which would require increased safety precautions
9. Is the resident currently using the side rail for position or support
10. Has the resident expressed a desire to have side rails raised while in bed

Licensed nurse D completed the screening on 9/6/18 with yes answers to all questions except #2 and #7. The screening failed to identify whether the side rails were or were not indicated for this resident. The screening did not include any information about the presence of rails still attached to the bed or directions not to use. The screening failed to include any information about the safety of the device or the gaps between the different areas of the rail to ensure the device was not an entrapment risk. Interview on 9/12/18 at 1:30 PM with licensed nurse D revealed he/she

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{S3155}	Continued From page 9	{S3155}		

was asked to complete the screening answering the questions but he/she was not comfortable with deciding on the use of side rails and planned to review with administrative nurse G.

The negotiated service agreement (NSA) dated 6/4/18 indicated the resident requested stand by assistance from staff with dressing/morning cares. The NSA lacked information about any assistive device or bed assistive devices.

The health service plan (HSP) dated 6/4/18 indicated the resident needed physical assistance of 1 staff for bathing/grooming, stand by assistance with dressing, physical assistance with toileting and stand by assistance with mobility and use of a walker but he/she was independent with transfers. The HSP indicated the resident had impaired vision, at risk for falls/unsteadiness and lacked information about the use of bed assistive devices.

The facility resident roster provided on 9/12/18 indicated the resident had bed rails attached to the bed.

Observation on 9/12/18 at 11:26 AM revealed the resident's bed had an upside down U-shaped assistive device attached to both sides of the bed and secured by straps under the mattress.

Interview with the resident on 9/12/18 at 11:26 AM confirmed the resident used the bed rail/assistive device to reposition in bed and to get in/out of the bed.

Interview on 9/12/18 at 1:35 PM with administrative nurse E confirmed the side rail rationale screen did not indicate whether the rails were or were not indicated for this resident and

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{S3155}	Continued From page 10 did not include information about the safety of the device as far as proper fit, gaps between sections or proper operation of the rail(s). The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident and in accordance with the functional capacity screening and negotiated service agreement in regard to the use of a bed rail/bed assistive device. - Review of the resident roster provided by the facility on 9/12/18 revealed 12 residents used a bed rail or assistive device which included resident #1216. Record review revealed an admission date of 6/25/18 for resident #1216 with diagnoses of history of cerebral vascular accident (stroke), muscle weakness, osteoarthritis of right knee, injury of rotator cuff, rheumatoid arthritis and anxiety.	{S3155}		

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{S3155}	Continued From page 11 The record lacked a functional capacity screen. The record included a side rail rationale screen which included 10 screening questions as follows: 1. Is the resident ambulatory 2. Is the resident comatose, semi-comatose, obtunded or has fluctuations in level of conscious 3. Does the resident have alteration in safety awareness due to cognitive decline 4. Does the resident have a history of falls 5. Has the resident demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed 6. Does the resident have difficulty with balance or poor trunk control 7. Does the resident have difficulty with postural hypotension 8. Is the resident on any medications which would require increased safety precautions 9. Is the resident currently using the side rail for position or support 10. Has the resident expressed a desire to have side rails raised while in bed Licensed nurse D completed the screening on 9/6/18 with yes answers to all questions except #1, #2, #7, #9 and #10. The screening failed to identify whether the side rails were or were not indicated for this resident. The screening failed to include any information about the safety of the device or the gaps between the different areas of the rail to ensure the device was not an entrapment risk. Interview on 9/12/18 at 1:30 PM with licensed nurse D revealed he/she was asked to complete the screening answering the questions but he/she was not comfortable with deciding on the use of side rails and planned to review with administrative nurse G. The negotiated service agreement dated (NSA)	{S3155}		

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{S3155}	Continued From page 12 6/18/18 indicated the resident occasionally had poor judgment with need for monitoring and guidance, required frequent redirection and validation from staff. The NSA directed staff the resident required extended service with assist of 1 staff for mobility, transfers, toileting, grooming/dressing. The NSA failed to include the use of a bed rail/assistive device. The record lacked a health service plan. Observation on 9/12/18 at 12:23 PM revealed a quarter size bed rail on the outside exit of the bed which freely moved up and down. Interview on 9/12/18 at 12:30 PM with direct care staff F and certified medication aide G confirmed the resident had the rail in the upright position when in bed and used the rail to hold onto during cares. Interview on 9/12/18 at 1:35 PM with administrative nurse E confirmed the side rail rationale screen did not indicate whether the rails were or were not indicated for this resident and did not include information about the safety of the device as far as proper fit, gaps between sections or proper operation of the rail(s). The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches	{S3155}		

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{S3155}	Continued From page 13 Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident and were in accordance with the functional capacity screening and negotiated service agreement regarding the use of bed rail(s)/assistive device(s). - Review of the resident roster provided by the facility on 9/12/18 revealed 12 residents used a bed rail or assistive device which included resident #1198. Record review revealed an admission date of 1/10/16 for resident #1198 with diagnoses of history of subdural hematoma, impulsiveness, anxiety, hemiplegia, overactive bladder, hypertension and diabetes mellitus type 2. The significant change functional capacity screen dated 4/16/18 indicated the resident had short-term and long-term memory deficit, memory/recall deficit and impaired decision making. He/she was unable to perform any tasks with activities of daily living (ADLs) or transfer self. He/she was at risk for falls and used a wheelchair. The record included a side rail rationale screen which included 10 screening questions as follows: 1. Is the resident ambulatory 2. Is the resident comatose, semi-comatose, obtunded or has fluctuations in level of conscious 3. Does the resident have alteration in safety awareness due to cognitive decline	{S3155}		

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{S3155}	Continued From page 14 4. Does the resident have a history of falls 5. Has the resident demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed 6. Does the resident have difficulty with balance or poor trunk control 7. Does the resident have difficulty with postural hypotension 8. Is the resident on any medications which would require increased safety precautions 9. Is the resident currently using the side rail for position or support 10. Has the resident expressed a desire to have side rails raised while in bed Licensed nurse D completed the screening on 9/6/18 with yes answers to all questions except #7, #9 and #10. The screening failed to identify whether the side rails were or were not indicated for this resident. The screening failed to include any information about the safety of the device or the gaps between the different areas of the rail to ensure the device was not an entrapment risk. Interview on 9/12/18 at 1:30 PM with licensed nurse D revealed he/she was asked to complete the screening answering the questions but he/she was not comfortable with deciding on the use of side rails and planned to review with administrative nurse G. The negotiated service agreement dated (NSA) 4/17/18 indicated the resident was not oriented to time or place and cannot remember or use information. His/her judgment was always poor and constantly put self at risk. The NSA directed staff the resident required extended service with assist of 1 staff for mobility, dressing/grooming and 2 staff for transfers and toileting. The NSA failed to include the use of a bed rail/assistive device.	{S3155}		

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{S3155}	Continued From page 15 The health service plan (HSP) dated 4/16/18 directed staff to provide physical assistance with all ADLs. The HSP indicated the resident used a wheelchair with assistance of 1 staff but failed to include the use of a bed assistive device. The HSP identified the resident as a fall risk and listed 16 separate fall episodes. Review of the nursing notes between 8/21/18 and 9/12/18 revealed an entry on 8/24/18 at 12:10 AM (0010) indicating staff found the resident sitting on the floor at the bedside. On 8/29/18 the resident had another fall from the bed with a plan to add a body pillow. None of the notes mention the use of a bed assistive device. Observation on 9/12/18 at 11:34 AM revealed the resident's bed was up against the wall along one side and the other side had a cane style bed assistive device. Interview on 9/12/18 at 11:37 AM with certified medication aide G revealed he/she did not know why the assistive device was on the bed because the resident did not really use it. The resident would sit his/her arm on it and hang his/her leg off the side of the bed at times. He/she thought maybe Hospice had provided it to help him/her not to fall from the bed. Interview on 9/12/18 at 1:35 PM with administrative nurse E confirmed the side rail rationale screen did not indicate whether the rails were or were not indicated for this resident and did not include information about the safety of the device as far as proper fit, gaps between sections or proper operation of the rail(s). The FDA (food and drug administration) Hospital	{S3155}		

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{S3155}	Continued From page 16 Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident and were in accordance with the functional capacity screening and negotiated service agreement regarding the use of bed rail(s)/assistive device(s). - Review of the resident roster provided by the facility on 9/12/18 revealed 12 residents used a bed rail or assistive device and resident #1510 was not identified as using a bed rail/assistive device. Record review revealed an admission date of 1/25/14 for resident #1510 with diagnoses of senile dementia, anxiety, hypertension, arrhythmia, depression and chronic urinary tract infection. The annual functional capacity screen dated 10/26/17 indicated the resident had short-term and long-term memory deficit, memory/recall deficit and impaired decision making. He/she required physical assistance with bathing,	{S3155}		

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{S3155}	Continued From page 17 dressing, toileting, transfers and was unable to walk/mobility. He/she was at risk for falls and used a wheelchair. The record included a side rail rationale screen which included 10 screening questions as follows: 1. Is the resident ambulatory 2. Is the resident comatose, semi-comatose, obtunded or has fluctuations in level of conscious 3. Does the resident have alteration in safety awareness due to cognitive decline 4. Does the resident have a history of falls 5. Has the resident demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed 6. Does the resident have difficulty with balance or poor trunk control 7. Does the resident have difficulty with postural hypotension 8. Is the resident on any medications which would require increased safety precautions 9. Is the resident currently using the side rail for position or support 10. Has the resident expressed a desire to have side rails raised while in bed Licensed nurse D completed the screening on 9/6/18 and answered questions #3, #5 and #6 with a yes answer. The screening failed to identify whether side rails were or were not indicated for this resident. The screening failed to include any information about the safety of the device or the gaps between the different areas of the rail to ensure the device was not an entrapment risk. Interview on 9/12/18 at 1:30 PM with licensed nurse D revealed he/she was asked to complete the screening answering the questions but he/she was not comfortable with deciding on the use of side rails and planned to review with administrative nurse G.	{S3155}		

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{S3155}	Continued From page 18 The negotiated service agreement dated 10/26/17 indicated the resident was not oriented to time or place and cannot remember or use information. His/her judgment was frequently poor. The NSA directed staff the resident required extended service with assist of 1 staff for mobility, dressing/grooming and 2 staff for transfers and toileting. The NSA failed to include the use of a bed rail/assistive device. The health service plan (HSP) dated 12/17/17 directed staff to provide physical assistance with all ADLs and 2 staff for toileting and transfers. The HSP indicated the resident used a wheelchair with assistance of 1 staff but failed to include the use of a bed assistive device. The HSP identified the resident as a fall risk and listed 4 separate fall episodes. Observation on 9/12/18 at 12:20 PM revealed the resident's bed was located with 1 side against the wall. This side of the bed had a quarter sized bed rail attached and in the upright position. The outer side of the bed did not have a rail attached but one was present in the room over by the 4-shelved bookcase. Interview on 9/12/18 at 12:30 PM with certified medication aide G revealed the resident would hold onto the bed rail(s) during cares but did not use them to reposition him/herself or to get in/out of the bed. Interview on 9/12/18 at 1:35 PM with administrative nurse E confirmed the side rail rationale screen did not indicate whether the rails were or were not indicated for this resident and did not include information about the safety of the device as far as proper fit, gaps between sections	{S3155}		

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{S3155}	Continued From page 19 or proper operation of the rail(s). The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident and were in accordance with the functional capacity screening and negotiated service agreement regarding the use of bed rail(s)/assistive device(s). - Review of the resident roster provided by the facility on 9/12/18 revealed 12 residents used a bed rail or assistive device and resident #1191 was identified as using a bed rail/assistive device. Record review revealed an admission date of 5/14/14 for resident #1191 with diagnoses of dementia, hypertension, chronic obstructive pulmonary disease, and diabetes mellitus type 2. The annual functional capacity screen dated 11/2/17 indicated the resident had short-term and long-term memory deficit, memory/recall deficit and impaired decision making. He/she required	{S3155}		

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{S3155}	Continued From page 20	{S3155}		

physical assistance with bathing, dressing and toileting with independence in transfers and walking. He/she was at risk for falls and used a walker.

The record included a side rail rationale screen which included 10 screening questions as follows:
1. Is the resident ambulatory
2. Is the resident comatose, semi-comatose, obtunded or has fluctuations in level of conscious
3. Does the resident have alteration in safety awareness due to cognitive decline
4. Does the resident have a history of falls
5. Has the resident demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed
6. Does the resident have difficulty with balance or poor trunk control
7. Does the resident have difficulty with postural hypotension
8. Is the resident on any medications which would require increased safety precautions
9. Is the resident currently using the side rail for position or support
10. Has the resident expressed a desire to have side rails raised while in bed

Licensed nurse D completed the screening on 9/6/18 and answered questions #1, #3, #5, #6 and #8 with a yes answer. The screening failed to identify whether side rails were or were not indicated for this resident. In the comment portion licensed nurse D wrote staff helped resident to a sitting position/standing position due to difficulty moving during bed mobility. The screening failed to include any information about the safety of the device or the gaps between the different areas of the rail to ensure the device was not an entrapment risk. Interview on 9/12/18 at 1:30 PM with licensed nurse D revealed he/she was asked

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{S3155}	Continued From page 21 to complete the screening answering the questions but he/she was not comfortable with deciding on the use of side rails and planned to review with administrative nurse G. The negotiated service agreement dated 11/2/17 indicated the resident was not oriented to time or place and cannot remember or use information. His/her judgment was occasionally poor and needed monitoring and guidance. The NSA directed staff the resident required stand-by assistance with transfers and required extended service of 1 staff for toileting. The NSA failed to include the use of a bed rail/assistive device. The health service plan (HSP) dated 11/2/17 directed staff to provide physical assistance of 1 staff for grooming, bathing, dressing and toileting. The HSP indicated the resident used a walker with verbal cueing but failed to include the use of a bed assistive device. The HSP identified the resident as a fall risk and listed a fall on 3/31/18 with directions to monitor and redirect with unsafe transfers and ambulation. Observation on 9/12/18 at 11:30 AM revealed the resident's bed was not against the wall and the side closest to the door had a upside down U-shaped bed assistive device located at the very top of the bed. Direct care staff J entered the room to the sound of the floor mat alarm and confirmed the bed assistive device was not securely attached and merely slid between the mattress and the box spring. The assistive device freely moved with minimal pulling force but was stopped by the bedside table from completely falling out. The gap between the 2 upright portions was approximately 10 inches. Interview on 9/12/18 at 11:30 AM with direct care	{S3155}		

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{S3155}	Continued From page 22 staff J revealed the resident did not use the device to move about in bed or to get in/out because he/she used the walker. Interview on 9/12/18 at 1:35 PM with administrative nurse E confirmed the side rail rationale screen did not indicate whether the rails were or were not indicated for this resident and did not include information about the safety of the device as far as proper fit, gaps between sections or proper operation of the rail(s). The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident and were in accordance with the functional capacity screening and negotiated service agreement regarding the use of bed rail(s)/assistive device(s).	{S3155}		
{S3211} SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS	{S3211}		

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{S3211}	Continued From page 23 (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g) (3) The facility reported a census of 78 residents. Based on observation and interview for all residents receiving facility management of medications, the administrator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on each over-the-counter (OTC) medication package or container in 2 medication rooms. This deficient practice affected residents (#1095, #1097, #1099, #1189, #1190, #1210, #1211, #1222, #1256, #1257, #1281, #1285, #1320, #1321, #1350, #1362, #1408 and #1409). Findings included: - The facility roster identified 55 residents who received facility managed medications. On 9/12/18 at 9:45 AM administrative licensed nurse E opened the lower level medication room.	{S3211}		

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{S3211}	Continued From page 24 Observation revealed cabinets with loose over the counter (OTC) medications and some in baskets or lidded containers within the cabinets as follows: A basket labeled with a room number contained 1 OTC medication labeled with the first name of a former resident #1211. Resident #1210 had 31 bottles/containers of OTC medications not labeled with the resident full name. Some containers had initials, first name or room number only. Resident #1222 had 3 bottles/containers of OTC medications labeled only with the room number Resident #1408 had 9 bottles/containers of OTC medications labeled with a first name or a last name but not both as the full name and 3 only having a room number and 1 no identification at all. Resident #1409 had 6 bottles/containers of OTC medications not labeled with the resident's full name with 2 labeled with first name and room number and 4 with just a room number. In a basket labeled with a room number different than the room number written on 1 OTC medication which administrative licensed nurse E reported resident #1189 used to reside in the other room and he/she identified the medication as belonging to resident #1189. The basket also had an unlabeled bottle of OTC medication. Resident #1190 had 2 bottles/containers of OTC medication labeled with a room number and one had the resident's first name only. On 9/12/18 at 10:35 AM certified medication aide (CMA) B opened the upstairs medication room. Observation revealed cabinets with loose OTC medications and some were in baskets or lidded containers within the cabinets as follows: Resident #1099 had a bottle of OTC cough medication labeled with a room number only	{S3211}		

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{S3211}	Continued From page 25 Resident #1097 had a bottle of probiotic OTC medications labeled with a room number only Resident #1095 had a bottle of OTC eye drops labeled with a room number only A basket labeled with a single room number that had 2 residents residing in the room (resident #1320 or resident #1321) had 3 bottles/containers of OTC medications labeled with a room number only. Resident #1350 had 2 bottles/containers of OTC medication labeled with room number only Resident #1362 had 1 bottle/container of OTC labeled with room number only Resident #1256 had 3 bottles/containers of OTC medications labeled with initials or room number only Resident #1257 had 4 bottles/containers of OTC medications labeled with room number, first name or first name with last initial, but none had the full name of the resident as required. Resident #1281 had 1 bottle/container of OTC fiber medication not labeled and CMA B identified the medication as belonging to resident #1281 A basket which CMA B identified as belonging to former resident #1285 who discharged about a month ago had 1 bottle of OTC vitamins with a room number. Interview on 9/12/18 at 10:45 AM with administrative licensed nurse E confirmed the OTC medications were not labeled properly with the resident full name. The administrator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on each over-the-counter (OTC) medication package or container in 2 medication rooms.	{S3211}		