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	175379	A. BUILDING _____ B. WING _____	C 12/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNONITE FRIENDSHIP COMMUNITIES INC	600 W BLANCHARD AVENUE SOUTH HUTCHINSON, KS 67505

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F 000	INITIAL COMMENTS A partial extended complaint survey into KS0000158338 was conducted by the Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid services on 12/03/20, 12/07/20, 12/08/20, and 12/10/20. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. On 12/08/20 Administrative Staff A and Administrative Nurse B were provided a copy of the IJ template and informed of the IJ, which notified them the facility failed to ensure the safety of a cognitively impaired, vulnerable resident when the facility utilized a U bar side rail on the residents' bed without an appropriate safety of use assessment. A 05/2019 side rail assessment revealed the resident did not need bed rails. On 11/15/20 around 05:00 AM staff found the resident with her head face down between the U bar and the air mattress, wrapped in a blanket with her knees on the floor which placed this resident at risk for serious injury and/or death related to entrapment/strangulation potential. The facility provided an acceptable plan for removal of the immediate jeopardy on 12/08/20. The survey team validated the immediate jeopardy was removed on 12/10/20 following the facilities implementation of the plan for removal of the immediate jeopardy. The deficient practice remained at a scope and severity of a D following the removal of the immediate jeopardy.	F 000		
F 700	Bedrails	F 700		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/15/2020

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.

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F 700 SS=J	Continued From page 1 CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: The facility census totaled 69 residents, with three residents (R) sampled for the assessment and safe use of bed rail and U-bars (a device used for bed mobility) to prevent accidental entrapment, serious injury, or death. The facility performed a "Side Rail Assessment" on 05/28/19, which indicated R1 was not an appropriate candidate for the use of side rails or a U-bar and the the facility failed to remove the U-bar from her bed at that time. On 09/25/20 the facility placed an air mattress on R1's bed with the continued use of the U-bar and did not conduct another "Side Rail Assessment", which further failed to	F 700		

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ensure the safety of the resident in use of the air mattress and the U-bar. On 11/15/2020 at approximately 05:00 AM, the facility staff found cognitively impaired and physically dependent, vulnerable R1 with her head lodged between the air mattress and the U-bar mounted to her bed and her body tangled in the blanket with her knees on the floor. These failures placed R1 in immediate jeopardy.

Finings included:

- A review of the 11/1/2020 "Physician's Orders Sheet" revealed R1 with the following diagnoses: dementia (a progressive mental disorder characterized by failing memory, confusion), hypertension (elevated blood pressure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder.

Review of R1's 07/21/20 "Quarterly Minimum Data Set" (MDS) revealed R1 had short and long term memory loss with moderately impaired decision making abilities. She required extensive assistance from two staff for bed mobility and transfers.

Review of the 10/19/20 "Annual MDS" revealed R1 had short and long term memory loss with moderately impaired decision making abilities. She required extensive assistance from two staff for bed mobility and transfers.

Review of R1's "Fall Care Area Assessment" (CAA) dated 10/19/20 revealed R1 could bear weight and required the use sit to stand mechanical lift for transfers. The resident recieved prescribed medication, which increased

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her risk of falls.

Review of R1's "Care Plan," last revised 11/17/20, revealed R1 had difficulty completing her Activities of Daily Living (ADL) and was at a high risk of falling. The "Care Plan" directed staff to provide extensive assistance with bed mobility and hand transfer bars (U-bars). The "Care Plan" alerted staff that R1 needed to be checked on frequently due to her memory impairment and seldom utilized the call light. R1 was to be monitored hourly and offered assistance as needed. On 11/17/20, staff revised the "Care Plan" to include R1 needed positioning in the center of her bed and body pillows were to be used for comfort and positioning. The "Care Plan" lacked interventions related to the use of the U-bar prior to the 11/17/2020 revision.

Review of the 05/28/19 "Side Rail Assessment" revealed R1 was cognitively impaired, lack awareness to exit the bed safely, and was not a candidate for the use of a side rail or a U-bar. The medical record lacked documentation of another "Side Rail Assessment" until two days after staff found R1 between her mattress and the U-bar on 11/17/20. Review of the 11/17/20 "Side Rail Assessment" revealed no change from the 05/28/19 assessment; however, the facility removed the U-bars from the bed at that time.

Review of the facility's "Accident Investigation Report" for R1's fall on 11/15/20 at 05:30 AM revealed the staff found R1 with her head between the mattress and the U-bar. She was face down with her body wrapped in her blankets, and her knees were on the floor. She had a small abrasion on her left elbow and a bruise to the back of her right hand. The resident could not

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explain what happened. The facility determined the causal factor as the staff had not positioned the resident in the center of her bed at 03:00 AM. The facility reported maintenance would remove the U-bar from the bed and revise the "Care Plan."

Review of the 11/15/20 at 09:28 AM "Progress Note" revealed at 05:15 AM, staff found R1 with her head between the mattress and the U-bar, face down with her body wrapped in her blankets, and her knees on the floor. The staff "gently set free" her head and then lifted R1 back into bed. They noted a small abrasion to the left elbow and a 4 centimeter (cm) bruise to the back of the right hand. The staff assessed R1's vital signs and neurological status, which were within R1's normal limits, and she denied any pain.

Review of R1's "Hospice Visit Notes" on 11/18/20 revealed R1 did not demonstrate any outward signs of pain during the visit, but the hospice staff noted a green fading bruise to the right side of the resident's neck, which appeared linked to the most recent fall. The hospice staff called the durable power of attorney (DPOA) and updated them on R1's condition. The Hospice staff also reviewed the "accident investigation report," dated 11/15/20, and noted that R1's head had been lodged between the U-bar and the mattress while her knees were on the floor.

Review of the original "Notarized Witness Statement" written on 11/15/20 by Certified Nurse Aide (CNA) G revealed she went into R1's room for the 05:00 AM check and found her caught up in her blankets, dangling off the bed, with her head between the mattress and the bed rail.

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Review of the undated revised "Notarized Witness Statement" by CNA G revealed when she checked on R1 at 05:00 AM, she found her tangled in the blankets, legs off the bed, and her face between the mattress and the U-bar. R1's face was facing towards the interior of the room/door. CNA G ensured R1 was breathing and blinking her eyes. She then summoned Licensed Nurse (LN) D to help unravel R1 and get her onto the bed. CNA G reported R1's right cheek was up against the U-Bar.

Review of the original "Notarized Witness Statement" dated 11/15/20 written by LN D revealed the resident had rolled off the edge of the bed and her head became lodged between the U-bar and the mattress, and noted her knees were on the floor and tangled in the blankets.

Review of the undated revised "Notarized Witness Statement" by LN D revealed they found R1 with her face pressed against the U-bar and facing downward with her knees and legs on the floor. "It appeared as if she had rolled out of bed." R1 did not display any signs or symptoms of pain or respiratory distress. LN D wrote R1's head was not "lodged" between the mattress and U-bar but R1 did have an indentation from the U-bar on her right cheek. LN D wrote R1 could move all her extremities and neck without any outward signs of discomfort and the staff utilized a gait belt to lift R1 into the bed.

Interview on 12/07/20 at approximately 04:30 PM with Hospice Nurse (HN) E revealed the resident had a purple and green bruise to the right side of her neck, which measured 2 inches long by 1 inch wide when she visited the resident on Wednesday 11/18/20. HN E stated she reported

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the bruise to one of the facility charge nurses.

Interview on 12/08/20 at 11:41 AM with CNA G revealed R1 was last physically given care on 11/15/20 around 03:00 AM. She revealed when she entered the room around 5:00 AM, she observed the resident with her head facing the floor between the air mattress and the U-bar. She clarified and stated, "I can't say her head was entrapped or wedged, but I was unable to move her related to her weight and the fact she was wrapped up in a blanket with her knees/legs resting on the floor." She revealed she immediately checked to see if the resident was breathing because she was lying motionless and staring blankly at the floor. She reported calling the charge nurse to the room, and they lifted R1's head out of the space between the U-bar and the air mattress, placed R1 on the floor, and assessed her for injuries. She denied any bruising to R1's neck the last time she saw the resident.

Interview on 12/08/20 at 11:20 AM with LN F revealed "Bed Rail Assessments" are done every three months. She revealed residents should not have a bed rail or U-bar if they are not cognitive enough to use it for positioning. LN F stated if a resident were caught between the mattress and the U-bar, she would remove them from the danger, assess them, contact the physician, and remove the U-bar immediately.

Interview on 12/03/20 at approximately 05:30 PM with Administrative Nurse B revealed staff found R1 on 11/15/20 at approximately 05:00 AM during hourly rounds. After learning of the incident on 11/16/20, she assessed R1's mattress and U-bar and determined they had been installed properly.

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Administrative Nurse B reported that after having the witnessing staff clarify their statements, they determined that R1's head had not been entrapped due to being easily removed and during their investigation determined the causal factor for the incident was because R1 had not been placed in the center of the bed during the last check. She did not know why the "side rail assessment" had not been performed since 05/18/19 or why the U-bar had not been removed at that itme.

Interview on 12/03/20 at approximately 5:15 PM with Administrative Staff A revealed Administrative Nurse B completed a total investigation of the incident and she determined the resident did not suffer any adverse effects related to the incident and they chose not to report it related to the outcome of that investigation.

Interview with Licensed Physician C on 12/8/20 at approximately 02:20 PM revealed she preferred to be notified the day of a significant incident happened and not faxed by the facility. She revealed she considered R1's incident significant however the facility faxed her staff on 11/15/20 when the office was not opened. She revealed she had discussed the incident with the facility's Quality Assurance team members during a phone conference shortly after the fall on 11/15/2020.

Review of the facility "Assist Devices Policy" last revised on 11/19 revealed "Transfer Bar, (Grab bar, safety bar, U-bar)" is a metal or plastic bar that attaches to the bed. Transfer bars are used to assist residents with turning, sitting, or standing position, allowing them more independence with bed mobility. The facility utilized a person-centered approach when determining the

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use of assistive devices such as side rails, transfer bars, and transfer poles. If after an attempted to the side/bed rails, transfer bars, has been made, and the alternatives do not meet the resident's needs, the facility shall: Evaluate the alternatives and document how these alternatives failed to meet the resident's assess needs. If there is no appropriate alternative, document reason. Assess the resident for risks of entrapment, and other risks associated with the use of side/bed rails, transfer bar, etc. The facility will ensure the correct installation and maintenance of assistive device."

The facility failed to ensure an environment free of potential accident hazards, when the facility utilized a "U bar" side rail for a cognitively impaired, vulnerable R1 after a 05/2019 side rail assessment revealed the resident did not need bed rails. On 11/15/20 around 05:00 AM staff found the resident with her head face down between the U-bar and the air mattress, wrapped in a blanket with her knees on the floor which placed this resident at risk for serious injury and/or death related to entrapment/strangulation. The facility had not in-serviced staff regarding safety measures in positioning residents with air mattresses and U-bars. By not ensuring the appropriate assessments for use of a U-bar on a cognitively impaired and dependent resident with a history of falls, the facility put the resident at risk for strangulation, suffocation, bodily injury and/or death potentially on 11/15/20 when they found the resident tangled in her blanket, with her head "lodged" between the air mattress and the U-bar, with only her knees on the floor.

Administrative Staff A and Administrative Nurse B were notified on 12/08/20 at 05:15 PM of the

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immediate jeopardy.

The facility presented an acceptable plan for removal of the immediate jeopardy on 12/08/20.

The removal plan included:

a. A root cause analysis was conducted by staff on 11/15/2020. On November 16, the incident review team (a QAPI sub-committee) met to review incidents from the weekend which included the incident which involved a U-Bar. Investigation of incident was initiated on 11/16/20. The U-bar was reassessed on resident and removed from the resident's bed on 11/17/2020.

b. Safety Committee (a QAPI sub-committee) reviewed incident on November 19th and assigned audits on all U-bars.

c. Audits were conducted on November 20th and reviewed with maintenance director, DON, and Administrator. Maintenance staff on same day (20th) adjusted any U-Bars identified on the audit as a potential for safety hazard.

d. QAPI audited U-Bars again on November 25th. Maintenance director made additional adjustments based on the audit of November 25th.

e. On 12/04/20 the DON and Clinical Care Coordinator reviewed Side-rail/U-Bar assessments and care plans on all residents currently using U-Bars to ensure an assessment was completed according to policy and procedure and care plan matched assessment.

f. Assistive Device policy and procedure was

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updated on 12/08/20 with new title, "Adaptive Bed Equipment and to include completing quarterly assessments in addition to on admission, with a significant change and annually, maintenance to check adaptive bed equipment quarterly for proper fit and document the quarterly check in MFC's Worx-Hub system. MDS Coordinators are responsible to ensure assessments are completed prior to locking the MDS.

g. Mini-in-service started on 12/08/20 for Direct Care staff, Licensed nurses, Environmental staff and MDS Coordinators' on the updated policy and procedure and education regarding adaptive bed equipment safety.

h. On 12/09/20 the clinical team revised the Side-rail Assessment (see attachment); changing the name to "Adaptive Bed Equipment Assessment", and revising assessment questions with interventions to consider.

i. All residents using adaptive bed equipment will be reassessed on 12/09/20 using the new I Assessment and based on that assessment their care plans will be updated accordingly.

j. A mandatory all staff Relias in-service has been assigned on "Side-rails: A hidden Danger". Staff must complete this in-service by 12/16/2020.

k. QAPI Committee met on 12/09/20 to develop the abatement plan of Correction. It was determined to conduct adaptive Bed Equipment audits weekly x 4 weeks then monthly x 3 months. These audits will be brought to QAPI monthly for review.

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F 700	Continued From page 11 The surveyor onsite verified the removal plan implementation on 12/10/20. The deficient practice remained at a D scope and severity following removal of the immediate jeopardy.	F 700		