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	B078030	A. BUILDING: _____ B. WING _____	01/14/2019

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 1/10/19 and 1/14/19.	S 000		
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus 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 26-42-204(a) The facility reported a census of 12 residents. The sample included 3 residents and 1 focused review for use of a bed assistive device. Based on observation, interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs for 3 of 4 sampled residents (#286, #298 and #311) in accordance with the functional capacity screening and negotiated service agreement. Findings included: - Record review for resident #286 revealed an admission date of 12/21/17 with diagnoses of hypertension, end stage renal disease, chronic	S5155		

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

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obstructive pulmonary disease, pain, general anxiety, hypothyroidism, insomnia and phantom limb.

The annual function capacity screen (FCS) dated 12/21/18 indicated the resident was unable to perform bathing, dressing, toileting and transfers with physical assistance needed with mobility and eating. He/she was unable to administer his/her own medications and treatments. The FCS indicated the resident used a mechanical lift and a wheelchair but did not identify the use of bed rails/assistive device.

The negotiated service agreement (NSA) dated 12/21/18 indicated facility nursing staff would provide personal care services of bathing, toileting, incontinence, mobility, transfer, escort to outside medical/dental appointments, dressing and grooming. The NSA indicated facility staff would transport the resident to and from dialysis services 3 times a week. The NSA did not identify any assistive devices used.

The health service plan dated 12/21/18 included directions for staff to send a lunch with resident to dialysis 3 times a week and transport to/from dialysis 3 times a week. The HSP lacked identification of the location of the dialysis access site, care of the site, monitoring needs or any precautionary needs for the resident based on dialysis site/services. The HSP indicated staff would administer the resident's medications, assist with toileting, use of a bed pan and changing incontinent products. Staff propelled the resident in a wheelchair, used a full body lift to transfer the resident, dressed and undressed the resident, staff provided full assist with a daily bed bath and all hygiene/grooming needs. The HSP failed to include how many staff were needed to

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transfer the resident due to the use of a total body lift and how much assistance the resident needed to exit the facility in the event of an emergency. The HSP failed to include the resident used a full bed rail on both sides of the bed.

Record review revealed the record lacked an assessment to verify the bed assistive device was not a restraint, the resident used the bed assistive device safely and the bed assistive device design/attachment/gaps and mechanisms were safe.

Review of the nursing notes between 12/21/17 and 1/10/19 revealed no information about the use of the bed rails or falls from bed. On 7/1/18 at 4:42 PM licensed nurse B wrote when staff assisted the resident to the toilet staff noticed blood on the resident's jacket. It was coming from his/her port used for dialysis. The blood had soaked through the blouse and jacket. The resident's clothes and old bandage were removed, pressure applied, and a new bandage applied. There were no notes to indicate the status of the resident's port upon return from dialysis that day. On 12/13/18 at 3:55 PM licensed nurse A wrote resident returned from dialysis at 3:20 PM with blood on the entire front of his/her shirt and jacket which the resident still wore. Staff noted a red biohazard bag on the back of his/her wheelchair which had the resident's pillow, pillow case and pendant lanyard which also had blood on it. The resident reported the needle came out during his/her treatment.

Observation of the resident's room with licensed nurse A on 1/10/19 at 11:50 AM revealed a full body mechanical lift, an electric scooter and full bed rails on both sides of the bed. The side next to the window had the full rail in the upright

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S5155	Continued From page 3 position and the outer side had the rail down at the top portion of the rail but still in upright position at the foot of the bed. The rails attached firmly to the bed and the gap between the mattress and rail was less than 2 inches with the gap within the rails between each bar was approximately 5 and 1/2 inches. Interview with licensed nurse A on 1/10/19 at 12:10 PM confirmed the HSP lacked identification of the dialysis access site, care of the site, monitoring or precautions associated with the dialysis site/service. He/she confirmed the HSP lacked information about how much staff assistance was needed for cares, number of staff needed or how the resident would exit the facility in the event of an emergency. He/she confirmed the HSP lacked information about the use of bed rails and the record lacked an assessment for the safe use of the side rails, to ensure the rails were not a restraint and to ensure the device design/attachment/gaps and mechanisms were safe. 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.	S5155		

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S5155	Continued From page 4 The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs for this resident in accordance with the functional capacity screening and negotiated service agreement regarding number of staff needed for transfers, exiting the building in an emergency, dialysis services/care needs/monitoring/precautions and the use of bed rail/assistive device. - Record review for resident #298 revealed an admission date of 6/29/18 with diagnoses of dementia, depression, general anxiety disorder, glaucoma, macular degeneration, hypertension, cardiac arrhythmia and recurrent urinary tract infections. The admission functional capacity screen (FCS) dated 6/29/18 indicated the resident had short-term and long-term memory impairment, memory recall deficit and impaired decision making. He/she was independent with transfers, walking/mobility and was at risk for falls. The FCS did not include the use of a bed assistive device. The negotiated service agreement (NSA) dated 6/29/18 indicated staff provided the resident assistance with bathing, incontinence if needed and escort to outside medical/dental appointments. The NSA indicated the resident may have times of short-term memory loss and staff should encourage and cue as needed offering support. At the time of the NSA the resident received physical therapy and staff were to monitor for falls and fall prevention. The health service plan (HSP) dated 6/29/18 indicated the resident could independently manage his/her own incontinence, oral care,	S5155		

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dressing, hygiene/grooming, walked with a walker and used a wheelchair for longer distances. The HSP did not include the use of a bed assistive device.

Record review revealed the record lacked an assessment to verify the bed assistive device was not a restraint, the resident used the bed assistive device safely and the bed assistive device design/attachment/gaps and mechanisms were safe.

Review of the nursing notes between 6/29/18 and 1/10/19 revealed no information about the use of the bed rails or falls from bed.

Observation on 1/10/19 at 12:15 PM revealed the resident walked from his/her room to the dining room using a walker and stand by assist from a home health nurse. His/her room door was left open and observation revealed a bed cane assistive device attached to the outer right side of the bed. The opening of the bed assistive device and a solid canvas material covering the opening.

Interview on 1/10/19 at 12:33 PM with licensed nurse A revealed he/she was not aware the resident had a bed assistive device, confirmed the record lacked an assessment and the HSP did not include the use of the bed assistive device.

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

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S5155	Continued From page 6 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 operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs for this resident in accordance with the functional capacity screening and negotiated service agreement regarding the use of bed rail/assistive device. - Record review for resident #311 revealed an admission date of 12/28/17 with diagnoses of general anxiety disorder, disorder of the brain, chronic pain, major depressive disorder, macular degeneration, hypertension and dementia. The annual functional capacity screen dated 12/28/18 indicated the resident required physical assistance with transfers with use of a mechanical lift and a wheelchair for mobility. The negotiated service agreement (NSA) dated 12/28/18 indicated the facility would provide personal care services of bathing, toileting, incontinence, dressing, grooming, mobility, transfers and escorts to/from medical/dental appointments. Nursing services to be supervised included monitor vital signs, administer medications and treatment, review/report changes in function and condition, management of behavioral symptoms and monitor for falls and fall prevention. The resident will be in commons area during waking hours within view of the staff. The NSA lacked information about the use of	S5155		

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S5155	Continued From page 7 assistive devices such as a mechanical lift, wheelchair or bed rails. The health service plan (HSP) dated 12/28/18 directed staff to provide the resident assistance with toileting for bowel and he/she was incontinent of bladder. The resident was non-ambulatory, used a sit-to-stand lift and could propel him/herself in a wheelchair. The HSP did not include the use of a bed assistive device. Record review revealed the record lacked an assessment to verify the bed assistive device was not a restraint, the resident used the bed assistive device safely and the bed assistive device design/attachment/gaps and mechanisms were safe. Review of the nursing notes between 8/1/18 and 1/10/19 revealed no information about the use of the bed rails or falls from bed. Observation with licensed nurse A on 1/10/19 at 12:36 PM revealed the resident's bed had a quarter bed rail attached to the bed in the middle section on both sides and in the upright position. The bed rail was securely attached to the bed with the gap between the mattress and the rail less than 2 inches. The gap within the rails measured 5 and 1/4 inches between the horizontal bars. Interview on 1/10/19 at 12:36 PM with licensed nurse A confirmed the resident used the bed rails to aid with bed mobility and transfers. He/she confirmed the record lacked an assessment and the HSP did not include the use of the bed assistive device. The FDA (food and drug administration) Hospital	S5155		

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S5155	Continued From page 8 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 operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs for this resident in accordance with the functional capacity screening and negotiated service agreement regarding the use of bed rail/assistive device.	S5155		
S5300 SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility.	S5300		

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S5300	Continued From page 9 (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility reported a census of 12 residents. The sample included 3 residents and 1 focused review for use of a bed assistive device. Based on record review and interview the operator failed to ensure all medications and biologicals were administered for 1 of 3 sampled residents (#286) in accordance with a medical care provider's written order. Findings included: - Record review for resident #286 revealed an admission date of 12/21/17 with diagnoses of hypertension, end stage renal disease, chronic obstructive pulmonary disease, pain, general anxiety, hypothyroidism, insomnia and phantom limb. The annual function capacity screen dated 12/21/18 indicated the resident was unable to perform bathing, dressing, toileting and transfers with physical assistance in mobility and eating. He/she was unable to administer his/her own medications and treatments. The negotiated service agreement dated 12/21/18 indicated facility nursing staff would administer the resident's medications and treatments as prescribed by a physician.	S5300		

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S5300	Continued From page 10 The health service plan dated 12/21/18 indicated facility staff administered the resident's medications and treatments. Review of the interagency transfer orders from a hospital stay signed by a physician on 1/3/19 revealed an order to administer medications as written on the reconciliation of orders from the hospital. Review of the hospital medication reconciliation revealed the only order for alprazolam (an anti-anxiety medication) was 0.25 milligrams (mg) 1 tablet by mouth 2 times a day as needed for anxiety. Review of the January 2019 medication administration record (MAR) revealed staff administered alprazolam 0.25 mg by mouth twice a day (ordered prior to hospitalization 9/27/18). The MAR also included alprazolam 0.25 mg by mouth as needed - may have up to 2 extra pills, PRN (as needed) in 24 hours for general anxiety disorder (ordered prior to hospitalization 11/6/18). Neither of these 2 alprazolam orders matched the hospital discharge orders. Interview on 1/10/18 at 1:55 PM with licensed nurse A revealed he/she performed the readmission of the resident on 1/3/19 from the hospital. He/she reported reviewing the hospital discharge orders. He/she said the alprazolam 0.25 mg twice a day and 2 extra pills PRN were long standing orders prior to admission. He/she said when reviewing the discharge orders from the hospital he/she only focused on the change or unchanged medications identified as such in a column before the name of the medications. He/she confirmed staff administered the alprazolam twice a day without an order and the PRN order did not match the prescribed directions with 1 administration on 1/7/19.	S5300		

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S5300	Continued From page 11 The operator failed to ensure all medications and biologicals were administered for this resident in accordance with a medical care provider's written order.	S5300		