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	N087083	A. BUILDING: _____ B. WING _____	11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNDER'S CREST, LLC	6887 E ROCKHILL STREET WICHITA, KS 67206

(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 the licensure resurvey for the above named facility conducted on 11/26/18, 11/27/18 and 11/28/18.	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 26 residents. The sample included 3 residents and 2 focused reviews. Based on observation, record review and interview the operator 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 5 of 5 sampled resident (#168, #179, #194, #219 and #223) regarding an attached assistive device, falls and behavior management. Findings included:	S3155		

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

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- Record review for resident #168 revealed an admission date of 6/15/17 with diagnoses of diabetes mellitus, dementia, hypertension and peripheral neuropathy.

The annual functional capacity screen dated 6/15/18 identified the resident with cognitive impairment of short and long-term memory, recall and decision making. He/she needed physical assistance with all activities of daily living (ADLs) except eating. He/she used a wheelchair and was at risk for falls.

The negotiated service agreement dated 6/15/18 indicated the resident would receive assistance from staff for regular toileting and as needed, dressing/undressing, grooming and ambulation.

The health care services dated 6/14/18 indicated the resident was incontinent of bladder at times, somewhat aware of toileting needs and can be resistive to assistance with toilet use. He/she required moderate assistance daily with toileting. He/she required moderate assistance with dressing/undressing for safety. The resident uses a wheelchair for mobility, 1-2 staff assistance for transfers to the bed and assist of 1 for transfer to the toilet because the resident used the grab bars. The HCS failed to include any information about the resident's fall risk or any specific safety measures needed. The HCS had no notation of a revision following 2 falls (8/29/18 and 10/5/18).

Review of the nursing notes revealed an entry dated 8/29/18 at 11:03 PM which indicated a caregiver heard a noise and entered the resident's room to find him/her sitting on his/her bottom in between the bed and the wall. The resident was in bed prior to the discovery and he/she reported getting up to shut the window,

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but the window was closed at the time. The resident was barefoot, floor was dry and free from clutter with no injuries noted. The note lacked any further information of why the resident fell, when was the resident last provided care or any other causal factors. The note lacked identification of an intervention to reduce the risk of further falls.

On 11/27/18 upon request the licensed nurse F provided a fall investigation dated 8/30/18. Review of the investigation provided no additional information as to why the resident fell, no statements from staff, no indicators for last toileted or cares provided. The fall investigation lacked any interventions to reduce the risk for further falls.

Nursing notes dated 10/5/18 at 9:32 PM revealed licensed nurse G recorded he/she received notification from staff of the resident sitting on the floor. Nurse G recorded staff reported doing 30-minute checks and when walked in the room found the resident on the floor. The resident stated he/she tried to get up from stool and fell. Nurse G assessed the resident without injury. The note lacked the location of where the resident was found on the floor, resident's prior known location, when staff last observed the resident or provided care, when the resident was last assisted to the toilet or any causal factors for the fall. The note lacked any interventions to reduce the risk of further falls.

Licensed nurse F reported he/she could not find a fall investigation for the 10/5/18 fall.

Interview on 11/27/18 at 4:00 PM with licensed nurse D confirmed neither nursing notes or investigations reflected a thorough investigation into causal factors thereby to develop

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interventions to reduce further falls. He/she confirmed the HCS lacked a revision to direct staff on how to reduce the risk of further falls for this resident.

The operator 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 this resident regarding falls.

- Record review for resident #179 revealed an admission date of 11/19/18. He/she had the following diagnoses: Lewy bodies dementia, Parkinson's, hypertension and depression.

The admission functional capacity screen (FCS) dated 11/19/18 indicated the resident had short and long-term memory deficit, impaired memory recall and decision making. He/she required physical assistance with all activities of daily living (ADLs), used a walker and/or wheelchair for mobility. He/she also was at risks for falls.

The negotiated service agreement dated 11/19/18 indicated the resident would receive assistance from staff for regular toileting and as needed, dressing/undressing, grooming and ambulation. Under the section for health care services the HCS included - licensed nursing staff will consult with physicians or primary care practitioners regarding all medications, medication changes; ensuring the care givers are aware of possible side effects; Behavioral symptoms - observation for changes in behavior indicating possible illness or pain.

The health care services (HCS) dated 11/19/18

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S3155	Continued From page 4 included under the section for mental attitude: the resident will interact at times with a small group, follows simple one step directions as times, was restless in the evening, became over stimulated with too much noise/activity and was restless/impulsive, needed to be on the go at times. The HCS lacked any interventions or directions to caregivers on how to manage these behaviors. The HCS included 1 staff assist with toileting tasks, frequently incontinent but does have some bladder control. He/she needed 1 assist with dressing/undressing. He/she needed moderate assistance with ambulation due to unsteady, shuffled gait and used a wheelchair for most mobility with assist from staff to get place to place. He/she can ambulate with a walker using a gait belt and staff assistance for short distances. Under additional notes bed alarm in place due to resident impulsive and transfers without assist, fall mat at bedside and bed in low position when in bed. The HCS lacked a revision following a fall on 11/20/18. The physician's orders dated 11/19/18 included Ativan (an antianxiety medication) 0.25 milligrams (mg) 1 tablet by mouth every 4 hours PRN (as needed) for restless/agitation. The orders included a sheet for redirection of behaviors prior to PRNs which directed staff to try interventions before administration of PRN medications as follows: 1. sit and visit one-on-one to try to help calm resident 2. back away and re-approach 3. walk with or wheel resident in wheelchair to a quiet, more calm area 4. engage resident in a one-on-one activity 5. offer food or drink 6. ask if they need to go to the bathroom or are they already soiled	S3155		

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7. are they hot/cold/bored/scared
8. hand off to another caregiver
9. play music (I Pod)
10. massage hand, neck, scratch back

If none of the appropriate approaches above are effective, talk to your nurse or call your on-call nurse. Let the nurse know what has been tried in the past that was effective.

Review of the nursing notes revealed an entry dated 11/20/18 at 10:14 PM certified staff reported to licensed nurse G the resident was on the floor in front of his/her wheelchair. The note indicated direct care staff reported the resident was in his/her wheelchair prior to the fall with other residents in the Morningside living room. Direct care staff went to assist another resident and heard a bump sound then observed the resident on the floor with his/her face on the floor. the resident had a bump on the upper right side of face 7 centimeters (cm) by 7 cm with no open areas and no sighs of neurological impairment noted with neurological exam. Two staff assisted the resident to stand, pivot and ambulate without difficulty to his/her wheelchair. The note lacked any information for the causal factors of the incident or interventions to reduce the risk of further falls.

On 11/27/18 licensed nurse F provided a fall investigation which indicated the fall occurred on 11/20/18 at 4:55 PM in the Morningside living room. The investigation provided no additional causal factors for the fall other than needed supervision. The investigation did not reflect a clear picture of where staff were at the time while assisting another resident to indicate if the staff were in fact supervising the resident. The investigation identified the resident to have a

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body and bed alarm in use due to high risk for falls caused by unsteady gait and dementia. The investigation did not identify if the body alarm was in use at the time of the fall. The information recorded under what cause the fall merely restated the resident was in the wheelchair before the fall and not witnessed with no conclusion for cause of the fall made. The investigation lacked a intervention to reduce the risk of further falls.

Observation on 11/26/18 at 3:55 PM revealed the resident in a wheelchair in a part of the living room close to the medication room and with other residents. He/she had a large fading bruise (brown, red, green) around the entire right eye.

Interview on 11/27/18 at 4:00 PM with licensed nurse D confirmed neither nursing notes or investigations reflected a thorough investigation into causal factors thereby to develop interventions to reduce further falls. He/she confirmed the HCS lacked a revision to direct staff on how to reduce the risk of further falls for this resident. He/she confirmed the HCS lacked specific interventions to address the resident's behaviors as identified and physician ordered to try before PRN medication use.

The operator 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 this resident regarding falls and behavior management.

- Record review revealed an admission date of 1/18/17 with diagnoses of dementia, orthostatic blood pressure, chronic pain and atrial fibrillation.

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S3155	Continued From page 7 The annual functional capacity screen dated 2/20/18 identified the resident with short and long-term memory deficit, impaired memory recall and decision making. He/she needed physical assistance with all activities of daily living except eating. He/she used a wheelchair and was at risk for falls. The negotiated service agreement dated 12/20/18 indicated the resident would receive assistance from staff for regular toileting and as needed, dressing/undressing, grooming and ambulation. The health care services dated 2/20/18 indicated he/she had some short and long-term memory loss - can make basic decisions. He/she needed moderate staff assistance with toileting as needed, assistance with dressing and undressing. He/she used a wheelchair for mobility, had positioning rails and a floor mat. He/she could propel independently in the wheelchair around the common areas. The HCS lacked a revision following the fall on 10/18/18. The facility resident roster provided on 11/26/18 failed to identify the use of an attached bed assistive device for this resident. Observation on 11/26/18 at 3:54 PM revealed an attached bed assistive device on both sides of the resident's bed. The device covered a quarter of the bed. The gaps within the rail in 1 section were greater than 5 inches. 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.	S3155		

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S3155	Continued From page 8 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. Review of the nursing notes revealed an entry dated 10/18/18 at 11:11 PM staff witnessed the resident fall out of his/her chair while trying to reach for something on the floor. Licensed nurse G received notification from direct care staff of the fall and he/she observed the resident on the floor in his/her back in the Morningside living room. The resident could not say what happened. Nurse G assessed the resident with an abrasion to the forehead of 6 centimeters (cm) by 2 cm, the nose bridge 1 cm by 0.5 cm, a skin tear on the left elbow 6 cm by 3 cm, a skin tear to top of left hand 7 cm by 2 cm, a skin tear at base of left middle finger 2 cm by 2 cm, a skin tear on top of right hand 2 cm by 0.5 cm with small open areas under the 2ndm, 3rd, 4th and 5th toes (did not specify which foot). All areas were cleansed, and dressing applied. No other injury noted. Three staff assisted the resident to an upright position and back into the wheelchair. The note did not include information related to where staff was, whether staff attempted to intervene since the fall was witnessed. The note did not include an intervention to reduce the risk of further falls.	S3155		

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S3155	Continued From page 9 On 11/27/18 licensed nurse F provided a facility fall investigation. The fall investigation indicated staff were behind the wheelchair with the resident at the time of the incident and the same information as recorded in the nursing note. Under corrective actions taken in response to this incident licensed nurse G recorded staff was with the resident at the time of the incident but unable to prevent the fall. The investigation did not include why the staff could not prevent the fall if the staff was with the resident and supervising him/her. The investigation did not include any staff statements. The section for cause of the fall restated the facts of reaching for something on the floor, fell out of wheelchair with multiple bruises and skin tears noted and staff with the resident at the time. The investigation lacked an intervention to reduce the risk of further falls. Interview on 11/27/18 at 4:00 PM with licensed nurse D confirmed neither nursing notes or investigations reflected a thorough investigation into causal factors thereby to develop interventions to reduce further falls. He/she confirmed the HCS lacked a revision to direct staff on how to reduce the risk of further falls for this resident. He/she confirmed the record lacked an assessment regarding the use of a bed rail/bed assistive device and confirmed the HCS lacked information about the bed rail use as related to safety, needed for, ability for the resident to use the rail safely or that the gaps did not create an opportunity for entrapment. The operator 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	S3155		

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negotiated service agreement for this resident regarding falls and use of a bed rail/bed assistive device.

- Record review for resident #219 revealed an admission date of 1/24/17 with diagnoses of dementia, hypertension, CVA, vertigo, macular degeneration, osteoporosis and anemia.

The functional capacity scree dated 8/22/18 identified the resident with short and long-term memory deficit, impaired memory recall and decision making. He/she needed physical assistance with bathing, dressing, toileting, transfers and was unable to walk. He/she was at risk for falls.

The negotiated service agreement dated 8/22/18 indicated the resident would receive assistance from staff for regular toileting and as needed, dressing/undressing, grooming and ambulation.

The health care services (HCS) dated 8/22/18 indicated the resident needed assistance of 2 staff and a total body lift to transfer into the wheelchair. The resident needed staff to check and change for incontinent bowel and bladder with physical assistance to provide perineal care. He/she needed physical assistance with dressing and undressing. The HCS lacked any information about the use of a bed rail/bed assistive device.

The facility resident roster provided on 11/26/18 failed to identify the use of an attached bed assistive device for this resident. Observation on 11/26/18 at 3:54 PM revealed an attached bed assistive device on both sides of the resident's bed.

The record lacked an assessment to verify the

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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.

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.

Interview on 11/27/18 at 4:00 PM with licensed nurse D confirmed no assessment was completed for use of the bed rail and the HCS did not reflect the use of a bed rail/assistive device.

The operator 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 the use of a bed rail/bed assistive device.

- Record review for resident #223 revealed an admission date of 10/16/17 with diagnoses of dementia, diabetes mellitus, depression and history of falls with fractures.

The functional capacity scree dated 3/28/18

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identified the resident with short and long-term memory deficit, impaired memory recall and decision making. He/she needed physical assistance with bathing, dressing, toileting, transfers and walking. He/she was at risk for falls.

The negotiated service agreement dated 3/28/18 indicated the resident would receive assistance from staff for regular toileting and as needed, dressing/undressing, grooming and ambulation.

The health care services (HCS) dated 3/28/18 indicated the resident needed assistance of 2 staff to transfer and used a wheelchair which staff propelled. The HCS indicated the resident had a hospital style bed with repositioning rails, fall mat and bed alarm.

The facility resident roster provided on 11/26/18 failed to identify the use of an attached bed assistive device for this resident. Observation on 11/26/18 at 3:48 PM revealed an attached bed assistive device on the outer side of the bed with the bed against a wall.

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.

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

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S3155	Continued From page 13 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. Interview on 11/27/18 at 4:00 PM with licensed nurse D confirmed no assessment was completed for use of the bed rail and the HCS did not reflect the use of a bed rail/assistive device. The operator 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 the use of a bed rail/bed assistive device.	S3155		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility 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 facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route.	S3200		

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	N087083	A. BUILDING: _____ B. WING _____	11/28/2018

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This REQUIREMENT is not met as evidenced by:
KAR 26-41-205 (d)

The facility reported a census of 26 residents. The sample included 3 residents and 2 focused reviews. Based on record review and interview the operator failed to ensure that all medications and biologicals were administered to 1 of 3 sampled residents (#179) in accordance with a medical care provider's written order and professional standards of practice.

Findings included:

- Record review for resident #179 revealed an admission date of 11/19/18. He/she had the following diagnoses: Lewy bodies dementia, Parkinson's, hypertension and depression.

The admission functional capacity screen (FCS) dated 11/19/18 indicated the resident had short and long-term memory deficit, impaired memory recall and decision making. He/she was unable to self-administer medications and treatments.

The negotiated service agreement dated 11/19/18 directed facility staff to administer and document all prescription and over-the-counter medications as ordered by a physician or primary care practitioner.

The health care services (HCS) dated 11/19/18 included under the section for mental attitude: the resident will interact at times with a small group, follows simple one step directions as times, was

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restless in the evening, became over stimulated with too much noise/activity and was restless/impulsive, needed to be on the go at times. The section for medication administration did not identify who should administer the resident's medications, identified the resident took medications willingly and failed to include any interventions to try before PRN medication administration.

The physician's orders dated 11/19/18 included Ativan (an antianxiety medication) 0.25 milligrams (mg) 1 tablet by mouth every 4 hours PRN (as needed) for restless/agitation. The orders included a sheet for redirection of behaviors prior to PRNs which directed staff to try interventions before administration of PRN medications as follows:
1. sit and visit one-on-one to try to help calm resident
2. back away and re-approach
3. walk with or wheel resident in wheelchair to a quiet, more calm area
4. engage resident in a one-on-one activity
5. offer food or drink
6. ask if they need to go to the bathroom or are they already soiled
7. are they hot/cold/bored/scared
8. hand off to another caregiver
9. play music (I Pod)
10. massage hand, neck, scratch back

If none of the appropriate approaches above are effective, talk to your nurse or call your on-call nurse. Let the nurse know what has been tried in the past that was effective.

Review of the November 2018 medication administration record (MAR) for resident #179 revealed certified medication aides (CMA) A, B

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and C initialed the front of the MAR to indicate administration of Ativan 0.25 mg on 11/20/18, 11/21/18 and 11/25/18. On the back side of the MAR in the section "Nurse's medication notes" CMA C made the only notation on 11/25/18 at 2:34 PM for Ativan 0.25 mg for resident very restless. The note did not identify any of the above interventions prior to the administration or contacting the nurse for assessment and directions regarding PRN administration.

Review of the nursing notes revealed an entry by licensed nurse D on 11/19/18 regarding the admission. On 11/20/18 at 10:14 PM was an entry about the resident falling from his/her wheelchair when staff were assisting another resident. The note did not include any information about the resident being restless whether before or after the fall and lacked any information about the administration of the PRN Ativan.

Interview on 11/27/18 at 3:50 PM with licensed nurse D confirmed the CMAs should contact the nurse before administering PRN medications. He/she confirmed the record lacked any evidence of interventions tried before PRN administration of the Ativan, Confirmed the record lacked information regarding the administration on 11/20/18 and 11/21/18. He/she confirmed the record did not have evidence of consultation with a nurse by the CMA before administration of PRN medications.

The operator failed to ensure that all medications and biologicals were administered to this resident in accordance with a medical care provider's written order and professional standards of practice.

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S3211	Continued From page 17	S3211		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (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 26 residents. The facility identified 25 residents received medication management by the facility. Based on observation, interview and record review the operator failed to ensure over the counter medications were labeled with the resident's full name on the package by a licensed nurse or pharmacist. Findings included: - The facility roster provided on 11/26/18 identified all 25 residents received facility management of his/her medications. On 11/26/18 at 4:04 PM certified medication aide (CMA) E opened the medication cart/medication	S3211		

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room for the Morningside unit. Observation revealed several over the counter (OTC) medications in the cart which were not labeled with a resident's full name as follows:
Resident #194 had 6 bottles of prescription eye drops or OTC eye drops. The prescriptions eye drops were not in the box which had the pharmacy label or there was no box, so the eye drops were not identified. CMA E identified all 6 bottles of eye drops belonged to the resident.
Resident #207 had 3 OTC medications not labeled with his/her full name or had no name, but CMA E identified as belonging to the resident.
Resident #211 had 2 bottles of OTC medications labeled with first name only or last name only.
Resident #212 had 1 bottle of OTC healing ointment labeled with his/her first name only.
The cart had the 7 bottles/containers of OTC medications, powders, oral rinse or suppositories without a label of which resident the item belonged to.

On 11/26/18 at 4:33 PM CMA E and licensed nurse D opened the medication cart/room for the Broadmoor unit. Observation revealed 1 OTC medication for resident #168 labeled with first name only. The cart had 4 OTC bottles/containers without any identification.

Interview on 11/26/18 at 4:05 PM with CMA E revealed he/she would write the resident name on the bottles when the family member brought them in.

Interview on 11/26/18 at 4:20 PM with licensed nurse D confirmed the above OTC medications were not properly labeled.

The operator failed to ensure over the counter medications were labeled with the resident's full

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S3211	Continued From page 19 name on the package by a licensed nurse or pharmacist.	S3211		