| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087023 | A. BUILDING: _____ B. WING _____ | 10/11/2018 |

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| WICHITA PRESBYTERIAN MANOR | 4700 W 13TH STREET NORTH WICHITA, KS 67212 |

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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of the licensure resurvey for the above named facility conducted on 10/9/18, 10/10/18 and 10/11/18. | S 000 | | |
| S3155 SS=E | 26-41-204 (a) Health Care Services<br><br>. (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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-204(a)<br><br>The facility reported a census of 71 residents. The sample included 6 residents. 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 1 sampled resident (#392) regarding an attached assistive device and 2 of 6 sampled residents (#392 and #531) regarding falls.<br><br>Findings included: | S3155 | | |

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

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| S3155 | Continued From page 1<br>- Record review for resident #392 revealed an admission date of 4/9/15 with diagnoses of: dementia, major depressive disorder, insomnia, pain and anemia.<br><br>The annual functional capacity screen (FCS) dated 2/14/18 indicated the resident had impaired short-term memory, memory recall and impaired decision making. He/she resident required physical assistance with bathing, supervision with toileting used a walker to ambulate independently with a high risk for falls. The FCS failed to identify the use of a bed assistive device.<br><br>The negotiated service agreement (NSA)/health service plan (HSP) dated 2/14/18 indicated the resident transferred independently and ambulated with an assistive device. Staff needed to cue and direct him/her for toileting needs, help with dressing, cueing for personal hygiene and he/she had a pendant alarm for safety. The NSA/HSP included fall risk/interventions and identified the resident with a fall on 1/31/18, 2/4/18, 2/12/18, 3/13/18, 9/20/18 and 10/2/18. The NSA/HSP lacked information/interventions for falls noted in the nursing notes on 5/30/18, 6/6/18 and 7/30/18. The NSA/HSP failed to identify the resident used an attached bed assistive device or any risks associated with the use of the device.<br><br>The facility resident roster provided on 10/09/18 failed to identify the use of an attached bed assistive device for this resident. Observation on 10/10/18 at 9:25 AM revealed an attached bed assistive device.<br><br>The bed rail screen dated 8/13/18 indicated no rails were in use and were not indicated for the resident at this time. | S3155 | | |

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| S3155 | Continued From page 2<br><br>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.<br><br>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:<br>Zone 1 within the rail should measure less than 4 and 3/4 inches<br>Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches<br>Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches<br>Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches.<br><br>Review of the nursing notes between 3/1/18 and 10/10/18 revealed the following entries about falls:<br>5/30/18 at 8:17 AM the resident sustained a non-injury fall at the bedside around 7:10 AM when staff found the resident sitting on the floor beside the bed. His/her call pendant was within reach, he/she wore non-skid footwear and his/her walker was in reach. The resident stated he/she was going to the bathroom. The resident was incontinent of bladder. The note failed to include a causal factor for the fall or an intervention to reduce the risk for further falls.<br>6/6/18 at 7:57 AM resident's call light sounded at 6:15 AM and when staff answered it he/she found the resident on the floor in the bathroom. The resident was on his/her left side with his/her head towards the bathroom door and walker noted | S3155 | | |

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turned backwards against the far bathroom wall. the light was off in the bathroom. The resident stated he/she was walking from the bed to use the bathroom when he/she must have slipped on something. The intervention listed included a work order issues for a motion sensor light in the bathroom. The NSA/HSP did not include this fall or the intervention.
7/31/18 at 1:42 AM which indicated at 8:45 PM on 7/30/18 staff responded to the call light and found the resident sitting on the floor near the bathroom door with his/her back against the wall. He/she was fully dressed with his/her shoes on. The resident said he/she slide off the bed while attempting to stand. The note included a fall intervention of a note reminder to use the walker placed on the walker. The NSA/HSP did not include this fall or the intervention to reduce the risk for further falls.

Observation on 10/10/18 at 9:25 AM revealed the resident rested in bed with a walker beside the bed. On the side of the bed closest to the bathroom was a bed assistive device attached to the bed frame.

Interview on 10/10/19 at 1:06 PM with licensed nurse A revealed he/she was not aware of the bed assistive device. Interview 10/10/18 at 3:30 PM licensed nurse A reported the facility conducted an internal review of the falls on 5/30/18, 6/6/18 and 7/30/18, made an intervention and confirmed the NSA/HSP was not updated.

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

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service agreement regarding the use of a bed rail/bed assistive device and interventions to reduce the risk of further falls.

- Record review for resident #531 revealed an admission date of 11/2/16 with diagnoses of: dementia, hypertension, pain, hemolytic anemia, coagulation defect and gout.

The annual functional capacity screen (FCS) dated 11/1/17 indicated the resident had impaired short-term and long-term memory, memory recall and impaired decision making. He/she needed physical assistance with bathing and application of support stockings, ambulated independently with a walker and at high risk for falls.

The negotiated service agreement (NSA)/health service plan (HSP) dated 11/2/17 identified the resident as independent with transfers, toileting with need for cueing/supervision and used a front wheeled walker for ambulation. The NSA/HSP identified a fall risk/prevention which included staff will monitor and identify for fall risk, assess and identify risk factors, provide interventions for fall prevention. The NSA/HSP did not include information about a fall on 10/5/18 (identified in the nursing notes).

Review of the September 2018 medication administration record and compared to signed physician orders dated 8/10/18 revealed the resident received clopidogrel 75 milligrams (a medication to decrease the clotting factor of the blood). The NSA/HSP failed to include the bleeding risk factors associated to the use of the medication in relation to fall risk and risks for injury.

Review of the nursing notes between 3/1/18 and

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| S3155 | Continued From page 5<br><br>10/10/18 revealed on 10/5/18 at 8:14 AM revealed staff found the resident on the floor at 8:05 AM wearing pajamas, glasses and slipper socks. The folding chair which was usually behind the recliner was near the window on the floor a few feet in front of the resident and the resident's walker was in front of the window. The resident was unable to state what happened. The note lacked a clear causal factor for the fall or an intervention to reduce the risk of further falls.<br><br>Interview on 10/10/18 at 3:30 PM with licensed nurse A revealed the facility conducted an internal review of the fall, made an intervention but failed to update the NSA/HSP.<br><br>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 interventions to reduce the risk of further falls. | S3155 | | |