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RIVER BEND ASSISTED LIVING	3820 BROADWAY GREAT BEND, KS 67530

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S 000	INITIAL COMMENTS The following citations represent the findings of the resurvey on the above named facility on 5/24/18 and 5/29/18.	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 40 residents. The sample included 3 residents who fell in the past 180 days. 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 3 of 3 sampled residents (#401, #402 and #403) regarding falls. The administrator also failed to ensure a licensed nurse assessed 2 of 2 sampled resident for side rail use (#401 and #402). Findings included:	S3155		

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- Record review for resident #401 revealed an admission date of 12/4/17. He/she had diagnoses of muscle weakness episodic delirium due to known physiological condition.

The Functional Capacity Screen (FCS) dated 12/4/17 indicated the resident required physical assistance with toileting, transfers, walking and mobility. He/she required total assistance with dressing and bathing.

The fall risk assessment dated 12/4/17 identified the resident as a high fall risk.

The Negotiated Service Agreement (NSA)/Health Care Plan (HCP) dated 12/4/17 indicated the resident needed assistance with toileting for safety related to unable to transfer him/herself independently so he/she needed assistance with getting on/off the toilet with help adjusting clothing. He/she could page for staff assistance. He/she required 1 staff member to perform all transfers safely. He/she was able to assist in the transfers with cueing. Fall Reduction Interventions included: 1-person assist using gait belt with all ambulation and transfers, appropriate footwear with all ambulation/transfers and Physical therapy (PT)/Occupational therapy (OT) evaluation and treatment. He/she could ambulate a very short distance with the walker and 1-person assist. The NSA/HCP identified the resident with mild cognitive impairment. The facility resident roster provided on 5/24/18 indicated the resident had side rails attached to the bed. The NSA/HCP listed assistive devices of walker and wheelchair but did not include the side rail use.

The record lacked an assessment to verify the side rail was not a restraint, the resident used the

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side rail safely and the side rail design/attachment/gaps and mechanisms were safe.

Review of the resident progress notes between 12/4/17 and 5/24/18 revealed a note dated 12/6/17 at 4:45 AM, a note dated 12/6/17 at 4:11 PM and fax to the physician on 12/6/17 the resident had a fall on 12/5/17 at 7:05 PM when he/she attempted to move the wheelchair out of the way and he/she slid from the recliner onto his/her bottom on the floor. Staff found the resident when he/she responded to the residents call light. The note indicated the resident had a small skin tear on the right (but did not specify the body location) which staff cleansed and bandaged. The interventions to address risk for further falls included: remind resident to use call light, encourage the resident to wait for staff assistance with transfers and especially with ambulation for safety. Resident to continue physical therapy (PT)/occupation therapy (OT) to regain strength and balance. The NSA/HCP lacked a revision to include this fall with any new interventions to direct staff in caring for this resident with a high fall risk and fall history.

12/7/17 at 3:27 AM resident cannot perform any activities of daily living (ADLs) independently. He/she was confused all the time and required assistance with dressing, toileting, moving and standing. He/she used a wheelchair to get around.

12/8/17 at 1:32 AM and a fax to the physician on 12/8/17 indicated the resident had a fall on 12/7/17 at 11:45 PM. The resident had activated his/her call light and when staff responded he/she found the resident on the floor on his/her bottom. He/she reported rolling out of bed. The fax

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indicated staff determined from the position of the resident it appeared he/she had tried to get up and slid to the floor. The note lacked an intervention to address risk for further falls. The next note 12/8/17 at 10:08 AM indicated the resident continued to have confusion and frequently mistook his/her call light for the phone or TV remote as he/she pushed the call light frequently. He/she maybe seeking attention as he/she stated, "I do not like to be alone". Nursing staff encourage participation in as many activities as resident will be open to attending. Family commented on cognition deficit similar to when the resident got very sick and requested the nurse try to get a urine analysis (UA) to rule out urinary tract infection (UTI). The NSA/HCP lacked a revision to include this fall with any new interventions to direct staff in caring for this resident with a high fall risk and fall history.

12/8/17 at 10:36 AM resident had slow slightly unsteady gait and had tried to put him/herself on the toilet. The writer reminded him/her to call for help and lock the wheel chair brakes.

12/8/17 at 8:19 PM indicated at 5:15 PM staff responded to the resident's call light and found him/her on the floor in the bathroom between the shower and toilet. The resident reported trying to go to the bathroom. He/she had activated the call light but did not wait for help. Intervention to address risk for further fall was the same as previous falls of encouraged to wait for staff to transfer. The NSA/HCP lacked a revision to include this fall with any new interventions to direct staff in caring for this resident with a high fall risk and fall history.

12/9/17 at 4:46 AM resident reminded to call for help getting up and around. He/she was still

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unsteady and at times required 2 staff to assist but was doing better with transfers.

12/11/18 at 12:55 PM physician noted incident notifications with new orders for a UA with diagnoses of confusion. Staff collected the UA and sent specimen to the lab.

12/12/17 at 2:46 PM UA indicated infection with E-Coli and the physician prescribed an antibiotic.

Subsequent notes indicated the resident continued to have varying cognition and ADL abilities. On 12/14/17 the physician saw the resident for routine follow-up and ordered to continue antibiotic, follow-up UA in 10 days, continue PT --- this had been difficult due to open case with a home health agency and the resident is not receiving therapy at this time.

12/27/17 at 5:35 PM indicated the resident had fallen at 2:40 PM when staff responded to the call light and found the resident sitting on the floor. The resident said he/she had stood without difficulty but when he/she went to grab the walker to look out the window he/she fell and landed on his/her bottom. The NSA/HCP lacked a revision to include this fall with any new interventions to direct staff in caring for this resident with a high fall risk and fall history.

1/8/18 at 4:00 PM resident was a 1 person assist with toileting and ADLs. The resident ambulated around the facility and his/her room with the assistance of a wheelchair. Resident was a 1 person assist for transfers and still with some confusion.

1/22/18 at 10:23 PM resident with increased confusion, paranoia, verbally and physically

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aggressive towards staff. Staff reminded the resident he/she was home, safe and try to get some rest.

1/24/18 at 7:54 PM resident had activated the call light at 7:15 PM and when staff entered the room found the resident sitting on the floor propped up next to the couch and recliner. When the resident was asked by 2 different staff why he/she was on the floor the resident gave each a different answer. The resident gave responses of getting on the floor to fold a blanket, being dizzy and needed to sit down, felling like he/she was having a heart attack and needed to get up. Resident denied pain at this time and refused to go to the emergency room. He/she had an inch long cut on his/her right arm by the wrist. Interventions remained the same as previous falls with reminding him/her to call for assistance and wait for staff. The resident could perform own ADLs with the wheelchair by could not stand by him/herself and needed assistance. The NSA/HCP lacked a revision to include this fall with any new interventions to direct staff in caring for this resident with a high fall risk and fall history.

2/24/18 at 9:36 PM staff made routine check on the resident around 7:30 PM and found the resident on the floor in front of the recliner in a fetal position with his/her head on the couch. The recliner was still in the reclined position. The resident had not activated the call light pendent which was around his/her neck. Staff had assisted the resident around 6:15 PM to the toilet and dress for the night then into the electric recliner and into a reclined position. The resident reported having pain on the left side which was the side he/she laid on. On-call nurse and Family member contacted directed to transport by

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ambulance to the emergency room for evaluation. The NSA/HCP lacked a revision to include this fall with any new interventions to direct staff in caring for this resident with a high fall risk and fall history.

2/25/18 at 3:58 AM resident returned to the facility around 12:30 AM by personal vehicle with family member. He/she had no change in condition, remained confused and reports having pain.

2/25/18 at 11:18 AM a nurse recorded a review of the fall incident and outcomes. Testing at the hospital resulted in no significant findings with orders to increase fluids, activity as tolerated, Tylenol for pain as needed and follow-up with primary care physician in next week. The note included no new interventions to address risk for further falls and indicated staff would encourage the resident to use the call light which he/she wore around the neck. Staff would continue to monitor the resident closely due to cognitive concerns and increased fall risk.

2/25/18 at 11:25 PM indicated staff making routine rounds at 9:15 PM found the resident's recliner tipped forward and the resident on the floor on all fours in front of the recliner with his/her head resting on the cushion of the couch. The leg rest of the recliner was still extended out and the resident's blanket were underneath him/her while his/her body kept the recliner in the tipped forward position. Staff had last checked the resident at 8:50 PM. When staff asked the resident if he/she had tried to get up he/she responded, "I guess so". The resident could not explain what he/she was trying to do and what he/she said did not make much sense. The note indicated the resident had been checked for UTI on 2 recent occasions with negative results. The

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nurse indicated staff would increase the frequency of checks on the resident and again encouraged the cognitively impaired resident to call for staff assistance. The NSA/HCP lacked a revision to include this fall with any new interventions to direct staff in caring for this resident with a high fall risk and fall history.

Review of the nursing notes between 2/25/18 and 3/13/18 revealed the resident had varying cognition and ADL ability. The resident was treated with antibiotic, antifungal and antiviral without much improvement and was hospitalized on 3/13/18 with return on 3/23/18 and no further falls.

Observation on 5/24/18 at 12:40 PM revealed the resident dressed, in the recliner with the foot rest elevated and remote within reach. He/she had a call light button around his/her neck. His/her bed had quarter sized rails attached to both sides of the bed.

Interview on 5/24/18 at 12:40 PM with the resident revealed he/she could converse but answered questions with disorganized thought and did not follow the conversation.

Interview on 5/24/18 at 11:12 AM with certified medication aide C revealed the resident was totally dependent on staff for ADLs except eating. He/she was a fall risk and staff provided hourly routine checks on him/her and answered the call light promptly.

Interview on 5/24/18 at 1:57 PM with licensed nurse E revealed if there was a side rail assessment done it would be a separate assessment in the electronic record. He/she confirmed the record lacked an assessment.

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S3155	Continued From page 8 Interview on 5/24/18 at 3:30 PM with licensed nurse E confirmed the resident progress notes included the entire information related to the fall and should have a causal factor and intervention. He/she confirmed the NSA included the HCP as 1 document/agreement. He/she confirmed the NSA/HCP did not reflect the actual falls the resident had or any additional interventions with each fall to address risk for further falls. The facility policy titled Fall Risk Evaluation (no date) indicated staff would complete the fall risk tool on a regularly scheduled basis to determine risk factors which may be attributed to falls. Fall Follow Up Protocol (no date) which directed staff on steps to follow based on the type of fall and none of these directed staff to evaluate for causal factors and development of interventions to address risk for falls further falls. 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 resident #401 regarding 7 falls. - Record review for resident #402 revealed an admission date of 1/8/18. He/she had the following diagnoses: dementia without behaviors, narcolepsy, hypertension and chronic kidney disease. The Functional Capacity Screen (FCS) dated 1/8/18 indicated the resident needed physical assistance with toileting, dressing/bathing and supervision with transfers, walking and mobility.	S3155		

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The fall risk assessment dated 1/8/18 identified the resident as a high fall risk.

The Negotiated Service Agreement (NSA)/Health Care Plan (HCP) dated 1/8/18 directed nursing staff to assist the resident with dressing/undressing, bathing and personal hygiene with cueing. He/she could independent toilet at times, required reminders and physical assistance to toilet as often as he/she should. He/she usually was independent with transferring up and down from chairs and in/out of bed but at time required cueing/oversight to complete these tasks. He/she ambulated with a walker and a tendency to shuffle his/her feet. On his/her best days he/she could ambulate without the walker but this was rare and not encouraged for safety reasons. The facility resident roster provided on 5/24/18 indicated the resident had hand rails attached to the bed. The NSA/HCP listed assistive devices of walker but did not include the hand rail use.

The record lacked an assessment to verify the hand rail was not a restraint, the resident used the hand rail safely and the hand rail design/attachment/gaps and mechanisms were safe.

Review of the resident progress notes between 1/8/18 and 5/24/18 revealed the following:

2/3/18 at 3:30 PM staff recorded receiving a page from the resident's pendent at 3:15 PM and found the resident sitting on the floor by his/her bed with knees drawn up. The family member in the room reported the resident slid out of the bed while trying to sit up on the side of the bed. The note lacked any interventions put into place to address risk for further falls of this type. The NSA/HCP

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lacked a revision related to the fall with causal factors and interventions to address risk for further falls.

4/7/18 at 11:22 PM staff recorded the resident had a fall this evening at 6:07 PM as he/she entered the room after supper. Staff was notified by a family member and found the resident on his/her right side by the refrigerator of his/her room. The note lacked a review of casual factors or interventions put into place to address risk for further falls of this type. The NSA/HCP lacked a revision related to the fall with causal factors and interventions to address risk for further falls.

4/9/18 at 3:30 PM the resident denies any pain or discomfort from fall. Resident is a one person assist with dressing. Resident ambulates around room and facility with assistance of walker and stand by assist.

5/10/18 at 6:00 AM family alerted staff the resident was on the floor. Staff found the resident in front of his/her bed with his/her feet to the side and underneath him/her with his/her face resting on the mattress. The resident did not know what happened and the family member was asleep but woke up to the resident lifting him/herself in the recliner and then crawling on the floor towards the bed. The resident did not want to go to the emergency room and had no visible injuries. The note lacked a review of causal factors or interventions put into place to address risk for further falls of this type. The NSA/HCP lacked a revision related to the fall with causal factors and interventions to address risk for further falls.

5/10/18 at 1:38 PM the nurse indicated performing a review of the resident's physical status and fall. It is likely that he somehow got to

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close to the edge of bed and slid out onto the floor based on his position at his bedside. Nursing staff had last peaked in on the resident at 4:00 AM and took him/her to the bathroom per normal routine. The note lacked any additional interventions put into place to address risk for further falls of this type.

5/13/18 at 4:14 AM indicated the resident remained on fall follow-up from 5/10/18. Staff entered the room and observed the resident kneeling on the floor with his/her head resting on the couch and a family member standing next to him/her. The note lacked a review of causal factors or interventions put into place to address risk for further falls of this type. The NSA/HCP lacked a revision related to the fall with causal factors and interventions to address risk for further falls.

Observation on 5/24/18 at 1:25 PM revealed certified medication aide (CMA) D propelled the resident in the wheelchair from the dining room to his/her bathroom. CMA D applied a gait belt, directed the resident to use the grab bar and attempted to help him/her stand. The resident could not or would not stand after 2 attempts CMA D went to get help from licensed nurse E. The resident stood with the assist of 2 staff, took a few steps with multiple cueing and pivoted to the toilet. CMA D reported the resident used the bed to sleep. The bed had a U-shaped hand rail attached to both sides of the bed.

Interview on 5/24/18 at 1:00 PM with CMA D revealed the resident was dependent on staff for activities of daily living (ADLs), could transfer at times with 1 staff but frequently needed 2 staff and he/she was a high fall risk. CMA D reported interventions to address fall risk were keeping an

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eye on the resident and provide him/her assistance when he/she tried to transfer/walk independently.

Interview on 5/24/18 at 1:57 PM with licensed nurse E revealed if there was a hand rail assessment done it would be a separate assessment in the electronic record. He/she confirmed the record lacked an assessment.

Interview on 5/24/18 at 3:30 PM with licensed nurse E confirmed the resident progress notes included the entire information related to the fall and should have a causal factor and intervention. He/she confirmed the NSA included the HCP as 1 document/agreement. He/she confirmed the NSA/HCP did not reflect the actual falls the resident had or any additional interventions with each fall to address risk for further falls.

The facility policy titled Fall Risk Evaluation (no date) indicated staff would complete the fall risk tool on a regularly scheduled basis to determine risk factors which may be attributed to falls. Fall Follow Up Protocol (no date) which directed staff on steps to follow based on the type of fall and none of these directed staff to evaluate for causal factors and development of interventions to address risk for further falls.

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 resident #402 regarding 5 falls.

- Record review revealed resident #403 admitted to the facility on 5/31/17. He/she had the following

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	N005006	A. BUILDING: _____ B. WING _____	05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BEND ASSISTED LIVING	3820 BROADWAY GREAT BEND, KS 67530

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diagnoses: insulin dependent diabetes mellitus, macular degeneration, coronary artery disease, congestive heart failure, hypertension, anemia and low back pain.

The Functional Capacity Screen (FCS) dated 5/31/17 indicated the resident was independent with toileting, transfers, walking and mobility.

The fall risk assessment dated 5/31/17 identified the resident as a high fall risk.

The Negotiated Service Agreement (NSA)/Health Care Plan (HCP) dated 5/31/17 indicated the resident was independent in getting up and down from chairs, in/out of bed, toileting and managing incontinence without assistance. He/she had poor vision, used a wheelchair for main source of mobility and a walker available in the room. He/she would use the wheelchair or walker with all mobility to help to address risk for falls.

Review of the resident progress notes between 7/10/17 and 5/24/18 revealed the following: 10/30/17 at 4:32 PM staff heard the resident hollering for help (around 4:00 PM) and found him/her on the floor on the left side in front of the wheelchair. The pillows on the wheelchair which he/she used for cushions were also on the floor. The resident denied injury and reported he/she had scooted too far forward in the wheelchair and just slipped off the edge of the seat. The resident was wearing the call light pendent but could not reach it from the position he/she was in. The note lacked any intervention to address risk for further falls. The NSA/HCP lacked information about the fall or interventions to address risk for further falls.

3/8/18 at 3:49 PM indicated staff heard the

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S3155	Continued From page 14	S3155		

resident calling for staff at 1:20 PM from inside his/her room. Staff found the door part way open but it was blocked by the resident's wheelchair. The resident laid on the floor in front of the kitchenette sink cabinets. He/she had been putting water away in the fridge, spilled a box of chocolates onto the floor and when he/she reached for them the wheelchair slid out from under him/her and he/she landed on the floor on his/her bottom. The wheelchair pillow was still underneath the resident and cushioned the fall. No apparent injury noted and staff assisted him/her back into the wheelchair. The note lacked any intervention to address risk for further falls. The NSA/HCP lacked information about the fall or interventions to address risk for further falls.

Interview on 5/24/18 at 3:30 PM with licensed nurse E confirmed the resident progress notes included the entire information related to the fall and should have a causal factor and intervention. He/she confirmed the NSA included the HCP as 1 document/agreement. He/she confirmed the NSA/HCP did not reflect the actual falls the resident had or any additional interventions with each fall to address risk for further falls.

The facility policy titled Fall Risk Evaluation (no date) indicated staff would complete the fall risk tool on a regularly scheduled basis to determine risk factors which may be attributed to falls. Fall Follow Up Protocol (no date) which directed staff on steps to follow based on the type of fall and none of these directed staff to evaluate for causal factors and development of interventions to address risk for further falls.

The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the

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S3155	Continued From page 15 needs of each resident and were in accordance with the functional capacity screening and negotiated service agreement for resident #403 regarding falls.	S3155		
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 40 residents. Based on record review, 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. Findings included:	S3211		

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S3211	Continued From page 16 - The resident roster identified 40 residents received facility management of medications. On 5/24/18 at 9:50 AM certified medication aide (CMA) C unlocked the only medication room. Observation revealed the following over the counter (OTC) medications labeled as "Stock" and not labeled with a resident's first and last name: Ibuprofen 200 milligrams (mg) (1 bottle of 1,000 tablets and 1 bottle of 250 tablets. Tylenol Extra Strength bottle of 100 tablets Tylenol 325 mg bottle of 100 tablets Alleve 220 mg bottle of 50 tablets Vitamin A & D ointment tube open and squeezed as if used Glucose tabs bottle of 50 tablets Calcium 600 mg bottle of 120 tablets Milk of Magnesia cherry flavored 26 ounces opened Mylanta 12 ounces opened Tums chewable 750 mg bottle of 96 tablets Antidiarrhea 2 mg bottle of 200 caplets with only a few left A box of antidirrhea unit dose package which had a resident's name that staff had marked out and identified as stock med since the resident did not have an order for it anymore. Bag of 30 cough drops opened Biotene Gel 1.5 ounce tube Triple antibiotic ointment 1 ounce tube Interview on 5/24/18 at 9:42 AM with CMA C revealed the resident's OTC medications are kept in the resident's room. He/she indicated when pharmacy delivered or family brought in the OTC the CMA or nurse would use preprinted labels of the resdient's first and last name to label the OTCs. He/she reported the stock medications are kept in the medication room.	S3211		

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S3211	Continued From page 17 Interview on 5/24/18 at 10:02 AM with CMA D revealed OTC medications are labeled by the CMA or nurse with preprinted labels of the resident's name. Interview on 5/24/18 at 3:30 PM licensed nurse E reported the nurse usually labeled the OTCs but the CMAs probably have labeled them on the weekends or evenings when family brings it. He/she was not aware of all OTC medications should be resident specific and not a stock medication. Review of the facility's policy for OTC medication (no date) revealed residents who have OTC medications in their possession in their rooms must meet state guidelines for the medication procurement, labeling and storage. 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 OTC medication package or container.	S3211		