STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019014	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW ESTATES	316 WICKWARE DRIVE FRONTENAC, KS 66763

(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 8/9/18 and 8/13/18.	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 28 residents. The sample included 3 residents. 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 2 of 3 sampled residents (#401 and #402) in regards bed rail/assuasive device use and falls. Findings included: - Record review for resident #401 revealed an admission date of 6/23/14. He/she had the	S3155		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019014	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW ESTATES	316 WICKWARE DRIVE FRONTENAC, KS 66763

(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
S3155	Continued From page 1	S3155		

following diagnoses: hypertension depression, anxiety and edema.

The annual functional capacity screen (FCS) dated 10/19/17 indicated the resident needed physical assistance with bathing, dressing and toileting. He/she had impaired decision making, used a walker and was at risk for falls.

The negotiated service agreement (NSA)/health care plan (HCP) dated 10/19/17 directed nursing staff to provide physical assistance to the resident with dressing/undressing, bathing and toileting. He/she required frequent reminders to use his/her walker. He/she required staff to provide prompts and cues related to impaired cognition of short-term memory, memory recall and decision making. The NSA indicated the resident received a hospital bed on 7/23/18 but did not indicate the bed included half-rails or the purpose for the half-rails.

The facility resident roster provided on 8/9/18 indicated the resident had bed rails attached to the bed.

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

Review of the resident progress notes between 10/28/17 and 8/3/18 revealed no entries about the resident's use of half-rails on the bed, the purpose or safety of half-rail.

Observation on 8/9/18 at 11:28 AM revealed the resident used a hospital style bed which had quarter rails on both sides with 1 side in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019014	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW ESTATES	316 WICKWARE DRIVE FRONTENAC, KS 66763

(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
S3155	Continued From page 2	S3155		

upright position.

Interview on 8/9/18 at 11:40 AM with licensed nurse F confirmed the resident had a hospital style bed with quarter side rails on both sides and the resident used the rails for bed mobility. He/she indicated he/she had started on policies for bed rail use in March of 2018 but as of 8/9/18 had not implemented any policies and confirmed the record lacked an assessment regarding the design/attachment/gaps and mechanisms for safety or that the resident could safely use the rails and the rails were not a restraint.

The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident and were in accordance with the functional capacity screening and negotiated service agreement regarding the use of bed rails.

- Record review for resident #402 revealed an admission date of 4/23/18. He/she had the following diagnoses: hypertension, pain and depression.

The admission functional capacity screen (FCS) dated 4/23/18 revealed the resident needed supervision with activities of daily living (ADLs) (bathing, dressing, toileting, transfers, walking/mobility). He/she had impaired decision making and was at risk for falls. The significant change FCS dated 6/13/18 indicated the resident now needed physical assistance with all ADLs.

The negotiated service agreement (NSA)/health care plan (HCP) dated 6/13/18 indicated staff would provide physical assistance with transfers, toileting, walking and mobility. He/she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019014	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW ESTATES	316 WICKWARE DRIVE FRONTENAC, KS 66763

(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
S3155	Continued From page 3	S3155		

impaired decision making with a family member appointed as durable power of attorney. The NSA/HCP identified the resident used a grab bar on the left side of the bed to assist with getting into/out of the bed and positioning. The operator indicated he/she had made the resident and family away of entrapment risk with possible injury. The NSA/HCP indicated the resident had falls/unsteadiness prior to admission and subsequent falls after admission as follows:
6/28/18 slid from the bed when he/she attempted self-transfer to use the bathroom. Intervention included resident strongly encouraged to use the call button before he/she gets up and reminded of his/her risks for injury.
7/17/18 resident was up independently in his/her room getting items from the closet when he/she had a bathroom urge with loose stool and attempted to sit down on the couch. Staff found the resident on seated on the floor in front of his/her couch. Intervention included reminded resident to use call button for assist before getting up.
8/3/18 resident rang call button after falling and staff found him/her on the floor in front of the apartment door. Intervention reminded resident to use call button for assist before he/she gets up.

The facility resident roster provided on 8/9/18 indicated the resident had bed rails attached to the bed.

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

Review of the resident progress notes between 4/23/18 and 8/8/18 revealed no entries about the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019014	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW ESTATES	316 WICKWARE DRIVE FRONTENAC, KS 66763

(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
S3155	Continued From page 4	S3155		

resident's use of half-rails on the bed, the purpose or safety of half-rail. The notes included the same falls as listed above. He/she also had falls as follows:
5/1/18 at 7:45 AM when staff went to room at 6:15 to get resident up for the day staff found him/her on the floor. The resident stated he/she slid out of bed. The resident could not recall why he/she had gotten up, his/her walker was next to him/her, but the call button was on the coffee table. He/she sustained a small abrasion on the left knee, cleaned and wrapped by staff and was assisted back to bed by 2 staff. The notes lacked any intervention to reduce the risk of further falls. On 5/4/18 at 9:00 AM licensed nurse F indicated the resident's silk pajamas were removed.
5/4/18 at 5:30 PM resident fell in the dining room. The resident said he/she had gotten up to go to his/her room and when resident turned towards another resident he/she lost his/her balance and fell landing on his/her left side. He/she sustained a small "L" shaped skin tear on the left elbow, left knee with black and blue area with swelling below the knee cap and denies pain. Staff cleaned the skin tear and applied ice to the left knee. Two staff assisted resident to ambulate to his/her room with use of walker and stand by assist without difficulty and no complaints of further injury. The note lacked any intervention to prevent further falls of this nature.
5/18/18 staff found resident sitting on his/her buttocks with back against the bed. The note indicated staff encouraged the resident to use the call light when needing to go to the resident and resident verbalized understanding.

Interview on 8/9/18 at 11:40 AM with licensed nurse F confirmed the resident had a hospital style bed with quarter side rails on both sides and the resident used the rails for bed mobility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019014	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW ESTATES	316 WICKWARE DRIVE FRONTENAC, KS 66763

(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
S3155	Continued From page 5 He/she indicated he/she had started on policies for bed rail use in March of 2018 but as of 8/9/18 had not implemented any policies and confirmed the record lacked an assessment regarding the design/attachment/gaps and mechanisms for safety or that the resident could safely use the rails and the rails were not a restraint. Interview on 8/9/18 at 1:35 PM with 1:35 AM with licensed nurse F confirmed the interventions of instructing the resident with using the call button was the same interventions with the falls on 5/18/18, 6/28/18, 7/17/18 and 8/3/18. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident and were in accordance with the functional capacity screening and negotiated service agreement regarding the use of bed rails and failed to develop effective interventions to reduce the risk of further falls.	S3155		
S3248 SS=E	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto;	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019014	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW ESTATES	316 WICKWARE DRIVE FRONTENAC, KS 66763

(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
S3248	Continued From page 6 (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102 (d)(1)(3) The facility reported a census of 28 residents. Based on interview and record review the operator failed to have evidence he/she verified the license for licensed nurse E prior to start of care for residents. The operator also failed to have evidence he/she checked the nurse aide registry for 4 of 4 certified nurse aides (CNA) or certified medication aides (CMA) hired since the last resurvey (CNA A and B, CMA C and D). Findings included: - Personnel record review on 8/9/18 revealed licensed nurse E began providing care to residents on 7/12/18 and the operator conducted a license verification for licensed nurse E on 8/7/18. Interview on 8/9/18 at 1:10 PM with operator F confirmed he/she knew the licensed nurse E personally and had failed to verify his/her license	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019014	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW ESTATES	316 WICKWARE DRIVE FRONTENAC, KS 66763

(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
S3248	Continued From page 7 before he/she began caring for residents. Personnel record review on 8/9/18 also revealed CNA A who began employment on 9/26/17 had an undated nurse aide registry verification in the file. The lack of dating on the document failed to show evidence the operator checked the nurse aide registry before allowing this CNA to provide care to residents. CNA B began employment on 1/3/17 and the personnel file included an undated nurse aide registry verification. CMA C began employment on 6/12/18 and the personnel file included an undated nurse aide registry verification. CMA D began employment on 5/9/17 and the personnel file included an undated nurse aide registry verification. Interview on 8/9/18 at 1:10 PM with operator F confirmed the personnel files lacked evidence of registry verification for CNA A and B, CMA C and D prior to provision of care for residents. The operator failed to have evidence he/she verified the license for licensed nurse E prior to start of care for residents. The operator also failed to have evidence he/she checked the nurse aide registry for 4 of 4 certified nurse aides or certified medication aides hired since the last resurvey (CNA A and B, CMA C and D).	S3248		