STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021006	A. BUILDING: _____ B. WING _____	R 10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARTEN COUNTRYSIDE HOME INC	2454 HWY 15 NORTH ABILENE, KS 67410

(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 a revisit at the above named residential healthcare facility conducted on 10/03/22.	{S 000}		
{S3171} SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (i) The census totaled 5 residents. The sample included 3 residents and 1 closed record review resident. Based on observation, interview and record review, Operator/Licensed Nurse (LN) A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice for the use of bed assistive devices, which met the needs of 1 of 3 sampled residents (R) 1801. Findings included: - Record review for R 1801 revealed she admitted on 03/16/18 with diagnoses of hypertension, diabetes mellitus type 2 and peripheral neuropathy. R 1801's current "Functional Capacity Screen" dated 08/05/22 recorded the resident as	{S3171}		

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

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{S3171}	Continued From page 1 independent with dressing, toileting, transfer, walk/mobility and eating, supervision required for management of medications and treatments, physical assist required for bathing and had impaired vision. The resident's "Negotiated Service Agreement" (NSA) dated 05/13/21 recorded R 1801 was independent with dressing, toileting, transfer and eating and required staff assistance with bathing, walk/mobility. The NSA recorded staff administered medications and treatments. The NSA failed to identify the use of a bed assistive device The resident's "Total Plan of Patient Care" dated 08/05/22 failed to identify the use of a bed assistive device. Observation on 10/03/22 at 12:20 PM in R 1801's room with Operator/LN A revealed a bed assistive device to the side of the bed. Bed assistive device unsteady when moved and not secured to bed. Operator/LN A confirmed device not secured to the bed and easily able to be pulled out from under bed. Interview on 10/03/22 at 11:46 AM with Operator/LN A confirmed no safety checks or bed assistive device assessments completed for R 1801. Record review lacked any assessment of the resident to confirm the device was not a restraint, an assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an assessment of the bedrail/assistive device to	{S3171}		

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{S3171}	Continued From page 2 ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment. 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. Facility's "Bed Rail Safety Guidelines" policy dated 08/03/22 recorded, "2. The mattress to bed rail interface should prevent an individual form falling between the mattress and bed rails and possibly smothering." Operator/LN A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs R 1801 regarding use of a bed assistive device. This failure placed R 1801 at risk for falls and potentially entrapment in the device.	{S3171}		
{S3216} SS=D	26-41-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of	{S3216}		

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{S3216}	Continued From page 3 all medications managed by the facility in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41 205 (i) (1) (A) (B) The facility reported a census of 5 residents. The sampled included 3 residents and 1 closed record review residents. Based on interview and record review, Operator/Licensed Nurse (LN) A failed to maintain records documenting the destruction of any discontinued controlled medications and biologicals according to acceptable standards of practice by two licensed nurses or a licensed nurse and a licensed pharmacist when three controlled medications for 1 Resident (R) 1500 were discontinued.	{S3216}		

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{S3216}	Continued From page 4 Findings included: - On 10/03/22 at 10:06 AM, Operator/Licensed Nurse A provided the "Resident Roster" and one discharged resident since last survey. R 1500 was the discharged resident. R 1500 discharged to funeral home on 08/07/22 - Review of R 1500's "Medical Record" revealed he admitted to the facility on 04/21/22 with diagnoses of acute kidney failure, hypertensive heart disease with congestive heart failure, hypotension and atrial fibrillation. R 1500's "Functional Capacity Screen" dated 04/20/22 recorded the resident required physical assistance to manage his medications and treatments. R 1500's "Negotiated Service Agreement" dated 04/21/22 recorded the facility staff would manage the resident's medications. Signed physician order dated 05/25/22 recorded, "Lomotil (diphenoxylate/ atropine) (medication to treat diarrhea) 2.5 milligrams (mg) by mouth three times per day. Review of facility's "medication disposal log" for R 1500 recorded three entries for Lomotil 2.5 mg: quantity 21 tablets, 20 tablets and 21 tablets. The record lacked signatures of a second licensed nurse or a licensed pharmacist in the "witnessed by" portion on the "medication disposal log." Interview on 08/03/22 at 12:10 PM with	{S3216}		

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{S3216}	Continued From page 5 Operator/LN A confirmed records lacked signatures of two licensed nurses or a licensed nurse and a licensed pharmacist for the three discontinued controlled medications for R 1500. Facility's "Narcotic-Controlled Medication" policy dated 08/03/22 recorded, "Unless otherwise specified in state or pharmacy regulations, the destruction/disposal process of controlled medications should always include two licensed persons (not specifically limited to health care professionals). Ideally, one of the two licensed persons is not routinely involved with administration assistance with medications." Operator/LN A failed to maintain records documenting the destruction of any discontinued controlled medications and biologicals according to acceptable standards of practice by two licensed nurses or a licensed nurse and a licensed pharmacist when three controlled medications for 1 Resident (R) 1500 were discontinued.	{S3216}		