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COVENANT CARE SENIOR LIVING	14422 TWINLAKE DRIVE WICHITA, KS 67230

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S 000	INITIAL COMMENTS The following citations represent the results of a Resurvey with complaint investigation #167834 for the above named Home Plus facility conducted on 06/14,15,/022.	S 000		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)(2)(3) The facility reported a census of eight residents(R). The sample included 3 residents. Based on observation, interview, and record review for 3 (R614, R615, R616) of 3 sampled residents the operator failed to ensure the written "Negotiated Service Agreement" (NSA) was based on the resident's "Functional Capacity Screen", service needs, and preferences. The NSA failed to include a description of all the	S5105		

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

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services the resident would receive, the provider of those services, and the part responsible for payment if outside resources provided a service for the resident.

Findings included:

- Review of R614's medical record revealed she moved into the facility on 02/01/22 with diagnoses of anxiety, depression, pain, and hypertension.

R614's "Functional Capacity Screen" dated 02/01/22 revealed the resident was unable to perform the task for bathing, dressing, toileting, transfers, walking/mobility, and required physical assistance with meals. The resident also could not manage her medications and medical treatments, had bladder incontinence, impaired cognition, had a current problem with falls/unsteadiness, impaired decision making, wandering and inappropriate behaviors.

R614's "Negotiated Service Agreement" dated 02/01/22 failed to identify that the facility would provide services related to the resident's current problem with falls/unsteadiness, impaired decision making, wandering and inappropriate behaviors. It also lacked information that staff would provide any services related to the resident's impaired cognition.

On 06/15/22 at 03:26 PM Administrative staff A acknowledged being unsure of exactly what needed to go into the development of a residents NSA and acknowledged R614's NSA did not address facility services for all service needs identified on the resident's FCS.

The operator failed to ensure areas where the FCS identified service needs for R614 related to

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falls/unsteadiness, impaired decision making, wandering, and inappropriate behaviors were addressed in the resident's negotiated service agreement.

- Review of R615's medical record revealed she moved into the facility on 03/26/22 with diagnoses of diabetes mellitus and diarrhea.

R615's "Functional Capacity Screen" dated 03/16/22 revealed the resident required supervision with bathing and dressing, had impaired cognition, current problem or risk for falls, had impaired vision and hearing and had impaired decision-making ability. It also identified the resident was unable to manage her own medication and medical treatments.

R615's "Negotiated Service Agreement" dated 03/17/22 failed to identify services staff needed to provide related to the residents impaired cognition, problem with falls/unsteadiness, and her impaired decision-making ability. It also failed to identify that the "Certified Medication Aides" (CMA) checked the resident's blood sugars via glucometer, prepared the resident's insulin pen, and dialed it to the correct dosage and then the resident self-injected the pen.

On 06/15/22 at 03:26 PM Administrative Staff A acknowledged being unsure of exactly what needed to go into the development of a residents NSA and acknowledged R615's NSA did not address facility services for all service needs identified on the resident's FCS.

The operator failed to ensure each residents negotiated service agreement was based on the resident's functional capacity screen and included a description of the services the resident related

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to medications/medical treatments, falls/unsteadiness, and impaired cognition.

- Review of R616 revealed she moved into the facility on 06/02/22 with a diagnosis if type two diabetes, muscle weakness, depression, and hypertension.

R616's "Functional Capacity Screen" (FCS) dated 06/02/22 identified she physical assistance with all activities except eating in which she was independent. She also had bladder incontinence, current problem with falls/unsteadiness and impaired hearing.

R616's Negotiated Service Agreement" dated 06/02/22 identified failed to identify the facility would provide services related to the resident's problem with falls/unsteadiness, impaired hearing or services related to cognition. It also failed to identify the resident would receive outside services from a home health agency for physical therapy and occupational therapy, who provided those services and who paid for those services.

On 06/15/22 at 03:50 PM Licensed Nurse B verified the resident admitted to the facility with orders for Home Health to provide therapy services.

On 06/15/22 at 03:26 PM Administrative Staff A acknowledged being unsure of exactly what needed to go into the development of a residents NSA and acknowledged R616's NSA did not address facility services for all service needs identified on the resident's FCS.

The operator failed to ensure R616's NSA identified that the facility would provide services related to the resident's current problem with falls,

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S5105	Continued From page 4 impaired hearing and failed to identify who provided outside services for therapy and who was responsible for payment of the service.	S5105		
S5117 SS=F	26-42-202 (e) NSA Nurse Participation (e) A licensed nurse shall participate in the development, review, and revision of the negotiated service agreement if the resident's functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-42-202 (e) The facility reported a census of eight residents (R). The sample included three residents. Based on record review and interview for all residents, the operator failed to have evidence to ensure a Licensed Nurse (LN) participated in the development, review, and revision of each residents (R614, R615, R616) negotiated service agreement who needed health care services. Findings included: - Review of R614's medical record revealed she moved into the facility on 02/01/22 with diagnoses of dementia. R614's "Functional Capacity screen" (FCS) dated 06/14/22 identified the resident required physical assistance with all activities of daily living, was unable to manage her medications and medical treatments, had impaired cognition and bladder	S5117		

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S5117	Continued From page 5 incontinence. R614's "Negotiated Service Agreement" (NSA) dated 02/01/22 included health care services to be provided by nursing staff, but failed to include the Licensed Nurse signature to show her participation in the development of the resident's NSA. On 06/14/22 at 9:57 AM Administrative staff A reported he completed the NSA and signed it with resident's legal representative and Licensed Nurse (LN) reviewed it. He acknowledged the LN did not sign the NSA. On 06/15/22 at 2:45 PM LN B acknowledged she just looked at the NSA for all residents after Operator A completes them. - Review of R615's medical record revealed she moved into the facility on 03/16/22 with diagnosis of type two diabetes. R615's FCS dated 03/16/22 revealed the resident needed supervision with bathing and dressing, could not manage medications or medical treatments, had bladder incontinence, and impaired cognition. R615's NSA dated 03/17/22 included health care services to be provided by nursing staff but failed to include the Licensed Nurse signature to show her participation in the development of the residents NSA. On 06/14/22 at 9:57 AM Administrative staff A reported he completed the NSA and signed it with resident's legal representative and Licensed Nurse (LN) reviewed it. He acknowledged the LN did not sign the NSA.	S5117		

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S5117	Continued From page 6 On 06/15/22 at 2:45 PM LN B acknowledged she just looked at the NSA for all residents after Operator A completed them. - Review of R616's medical record revealed she moved into the facility on 06/02/22 with diagnoses of type two diabetes, muscle weakness and hypertension. R616's FCS dated 06/02/22 revealed the resident needed physical assistance with all activities of daily living except for eating. She also had bladder incontinence and had a risk for falls/unsteadiness. R616's NSA dated 06/02/22 included health care services to be provided by nursing staff, but failed to include the Licensed Nurse signature to show her participation in the development of the residents NSA. On 06/14/22 at 9:57 AM Administrative Staff A reported he completed the NSA and signed it with resident's legal representative and Licensed Nurse (LN) reviewed it. He acknowledged the LN did not sign the NSA. On 06/15/22 at 2:45 PM LN B acknowledged she just looked at the NSA for all residents after Operator A completes them. For three sampled residents and all residents in the facility, the operator failed to ensure a LN participated in the completion, review, and revision of residents NSA.	S5117		

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S5155	Continued From page 7	S5155		
S5155 SS=D	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus 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 26-42-204 (a) The facility reported a census of eight residents (R). The sample included three residents. Based on observation, interview and record review the operator failed to ensure the licensed nurse provide or coordinate the provision of necessary health care services that meet the needs for 1 (R614) of 3 sampled residents in accordance with the "Functional Capacity Screen" and the "Negotiated Service Agreement" related to the resident's risk for falls. Findings included: - Review of R614's medical record revealed she moved into the facility on 02/01/22 with diagnoses of anxiety, depression, pain and hypertension. R614's "Functional Capacity Screen" (FCS) dated 02/01/22 identified the resident was unable to perform all activities of daily living except for eating in which she needed physical assistance. The resident also had impaired cognition and was	S5155		

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at risk for falls/unsteadiness.

R614's FCS dated 06/14/22 identified a significant change, but the resident was still identified at risk for falls.

R614's "Negotiated Service Agreement" did not identify any services specifically related the resident's risk for falls.

R614's "Health Service Plan" dated 02/01/22 identified the resident used a walker and needed stand by assistance at times of one staff. It identified she was at risk for falls and was unsteady.

Review of the resident's medical record revealed on 06/03/22 the resident fell out of her wheelchair. The resident had no apparent injuries and staff will continue to monitor. The record lacked any documentation that the resident had additional falls.

Surveyor requested evidence of investigation of falls on 06/15/22 and Licensed Nurse (LN) B provided one fall incident report form for R614 dated 06/08/22 at 04:30 PM. LN B stated this was the only report she could find. Review of the report provided revealed it was completed by CMA L and signed by LN B. The report revealed the staff found the resident on the floor in her room with the bed rails up and the alarm no on or sounding. It also identified the resident complained of pain in her right hand/wrist.

On 06/14 22 at 10:48 AM R614 sat at the dining room table and began to push her wheelchair back and forth. CMA C came over and spoke to the resident and then took her into the kitchen area where her and CMA D were pealing

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potatoes. Resident sat calmly in her wheelchair watching staff.

On 6/15/22 at 8:54 AM CMA C and CMA L put a gait belt on the R614 after she ate her breakfast. Staff stood one on each sid,e lifted the resident out of the wheelchair and guided the resident to step back and get into the recliner. Staff C lifted the feet of the recliner, put a pillow behind her head and put a lap cover on her.

On 06/14/22 at 12:06 PM CMA D reported the resident required assistance of two staff for transfers because when one person assisted her, she became scared. She required full assistance with all of her cares. She had a risk for falls and she would get "antsy" and so we took her with us in the kitchen or did something with her. She had a busy blanket, and it seemed she just wanted to be where the action was. If a resident had a fall, staff obtained vitals, called the nurse, determine the condition of the resident, and then determine the next course of actions.

On 06/14/22 at 12:52 PM CMA C confirmed the resident was at risk for falls. The resident forgot how to walk so they tried to keep their eyes on her. She would try and climb out of her recliner and tried to get out of wheelchair to be with staff in the kitchen.

On 06/15/22 at 03:22 PM while discussing the resident having a fall documented in the notes on 06/03/22, but no fall documented on 06/08/22 LN B acknowledged the facility did not complete an investigation of falls that identified the potential causal factors of falls and identify possible interventions to help reduce the risk of falls.

For R614, who staff identified at risk for falls on

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S5155	Continued From page 10 her FCS, the operator failed to ensure the LN thoroughly investigated the resident's falls for casual factors and possible interventions to reduce the risk for falls.	S5155		
S5165 SS=E	26-42-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(e) The facility reported a census of eight residents. Based on interview and record review for three of three newly hired Certified Medications Aide (CMA) employee files, the operator failed to ensure the delegated nursing procedure for monitoring blood glucose via glucometer for each CMA was completed by a licensed nurse under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included: - Review of employee records for CMA's F, CMA H, and CMA I revealed they did not have evidence of a licensed nurse delegation for the checking of a resident's blood sugar via glucometer. On 06/14/22 at 11:55 AM Administrative Staff J confirmed she did not have delegation forms to	S5165		

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S5165	Continued From page 11 identify that a licensed nurse delegated the procedure for monitoring blood glucose levels for residents who had orders for blood glucose monitoring. The operator failed to ensure certified medication aides were properly trained on the procedure monitoring blood glucose.	S5165		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (e) The facility reported a census of eight residents. Based on observation and record review the operator failed to ensure staff prepared food using safe methods and ensured staff served foods at the proper temperature for all residents	S5192		

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S5192	Continued From page 12 in the facility. - Observation on 06/15/22 at 12:06 PM beside the stove hung a piece of paper that had one column on it with temperatures. It identified the date but did not identify what type of food staff checked the temperature of. It also only had 1 column for taking temperatures one time per day instead of 3 times a day at each meal. On 06/15/22 at 12:08 PM "Certified Medication Aide" (CMA) C and CMA D both confirmed they only temperature of food that was taken was the meat. CMA D stated they only temp the meat to make sure it is cooked thoroughly. Confirmed they had never checked the temperature of cottage cheese, beans, potatoes, or other cold food items including eggs. On 06/16/22 at 7:54 AM CMA C reported they use regular eggs and do not use pasteurized eggs. Review of the undated "Sanitation" - "Food Service" policy revealed; "Cold foods shall be stored at 45 degrees Fahrenheit (F) or below. Hot food shall be 140 degrees or above." "... Shall cook potentially hazardous food which require cooking to at least 145 F. Poultry and poultry stuffing, stuffed meats and stuffing containing meat shall be cooked to a minimum temperature of 165 F... Pork and any food containing pork shall be cooked to a minimum of 150 F in all parts of the food." The operator failed to ensure facility staff prepared food using safe methods and failed to ensure foods were maintained and served and the proper temperatures.	S5192		

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S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(f) The facility reported a census of eight residents. Based on observations and interview the operator failed to ensure all foods were stored under safe and sanitary conditions. Findings included: - Observations during initial tour on 06/14/22 at 8:54 AM reveled the following sanitary concerns in the kitchen: 1. An unsealed box of crackers and an open, unsealed container of cookies located in one cabinet. 2. Plastic containers labeled sugar, brown sugar, rice, flour, and powdered sugar all with some type of measuring scoop in them with the handle touching the food. 3. A plastic container of "Chex-Mix", which also had a measuring scoop in it with the handle touching the food. On 06/14/22 at 09:02 AM the operator acknowledged if someone got into the container	S5195		

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S5195	Continued From page 14 and picked up the scoop and put it back it could possibly contaminate the rest of the food item in the container. Review of the undated "Sanitation" - "Food Service" policy provided on 06/15/22 included the following: "shall tightly cover and date each opened food item ..." and ..."shall protect the food from contamination." The operator failed to ensure all foods were stored under sanitary conditions.	S5195		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (d)(3)(4) The facility reported a census of eight residents.	S5215		

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S5215	Continued From page 15 Based on record review and interview the Operator failed to ensure disaster and emergency preparedness by the failure to conduct quarterly reviews of the home's emergency management plan with employees and residents. This failure affected all resident who lived in the facility. Findings included: - On 06/14/22 at 09:56 AM Operator A reported they reviewed the emergency plan on orientation and then annually. He acknowledged they did not review them with residents or staff quarterly. The Operator failed to ensure disaster and emergency preparedness by the failure to conduct quarterly reviews of the emergency management plan with all residents and all staff.	S5215		
S5230 SS=E	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced	S5230		

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S5230	Continued From page 16 by: K.A.R 26-42-207(c) The facility reported a census of eight residents (R). The sample included three residents and review of five newly hired employee files. Based on interview and record review for two (R614, R615) of three sampled residents and four of five newly hired employees, the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This failure had the potential to affect all residents in the assisted living facility. Findings included: - Review of R614's medical record revealed she moved into the facility on 02/01/22 and included a TB symptom screen and an initial TB skin test but failed to include a second TB skin test. - Review of R615's medical record revealed she moved into the facility on 03/16/22 and included a TB symptom screen and an initial TB skin test but failed to include a second TB skin test. The operator failed to ensure R614 and R615 received a two step TB skin test according to TB guidelines for adult care homes. - Review of five newly hired employees files revealed the following: "Licensed Nurse" (LN) B hired on 05/1/22 received a TB symptom screen and an initial TB skin test but did not receive a second skin test. "Certified Medication Aide" (CMA) F hired on 01/19/21 received a TB symptom screen but did	S5230		

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S5230	Continued From page 17 not have TB skin testing. CNA G hired on 10/29/21 received a TB symptom screen but did not have TB skin testing done. CMA I hired on 05/05/22 received a TB symptom screen, provided a one step TB skin test from a prior employer which was more that 6-month-old and did not receive TB skin testing upon hire. Employee record review revealed four of five newly hired employees did not have the TB skin testing completed by the facility according to TB guidelines. On 06/14/22 at 11:37 AM Administrative Staff J acknowledges the facility only completed a TB symptom screen and one TB skin test upon hire. On 06/15/22 at 02:42 PM LM B acknowledges that for resident's and staff the facility completed a TB symptom screen and only completed one TB skin test. Review of the "Tuberculosis Guidelines for Adult Care Homes" dated June 2013 revealed "Each new resident and new employee shall receive a two-step tuberculosis skin test (TST) ... within seven days of employment. For two of three sampled residents and four of five newly hired employees the operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S5230		
S5251 SS=D	26-42-105 (f) (11) Resident Records Documentation of Incidents	S5251		

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S5251	Continued From page 18 (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of eight residents (R). The sample included 3 residents. Based on interview and record review the operator failed to ensure the record contained documentation of all incidents, symptoms, and other indications of illness or injury including the time of occurrence, action taken, and results of the action for 1 (R614) of 3 sampled residents. Findings included: - Review of R614's medical record revealed she moved into the facility on 02/01/22 with diagnoses of anxiety, depression, pain, and hypertension. R614's "Functional Capacity Screen" dated 06/14/22 revealed the resident needed physical assistance with all activities of daily living, had bladder incontinence, and was at risk for falls. R614's "Negotiated Service Agreement" dated 02/01/22 identified the facility would provide supervised nursing services for personal care/ activities of daily living. R614's "Health Service Plan" dated 02/01/22 revealed one staff would assist the resident to the rest room every 3-4 hours, she used a walker at	S5251		

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S5251	Continued From page 19 times with stand by assistance of 1 staff and had occasional incontinence and wore incontinent products. It also identified the resident a fall risk but did not include any interventions to reduce the risk for falls. Review of the resident's record included the following progress notes: On 03/21/22 at 10:00 AM the resident needed to be fed, kept forgetting to eat. She also had dark smelly urine and complained of burning when urinating. The resident has had increased aggressive behaviors with confusion. Medical provider notified. The record lacked follow up as to what the physician did or on the changes in the resident's ability to feed herself, her increased aggressive behaviors or confusion. On 06/03/22 the resident fell out of her wheelchair. The Record lacked follow up as to the resident's status post fall. Review of an internal "Incident Report Form" provided by Licensed Nurse B, revealed staff found the resident on the floor in her room on 06/08/22 and had complaints of pain in her right hand/wrist. The resident's record lacked mention of the resident having a fall and any follow-up as to the resident's status post fall. The operator failed to ensure designated staff documented all incidents, symptoms, and other indications of illness or injury including the time of occurrence, action taken, and results of the action for 1 (R614) of 3 sampled residents.	S5251		
S5258 SS=E	26-42-102 (d) Staff Qualifications Employee Records	S5258		

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S5258	Continued From page 20 (d) The employee records and agency staff records shall contain the following information: (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; (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 carehome; 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 work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(d)(1)(2) The facility reported a census of eight residents. Based on record review and interview, the operator failed to provide evidence of licensure, registration, and certification for one of five newly hired staff that required specialized education and training. Findings included: - Review of five newly hired employee records revealed Licensed Nurse B was hired on	S5258		

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S5258	Continued From page 21 05/01/22 and did not have a licensure check completed upon hire. On 06/14/22 at 11:37 AM Administrative staff J acknowledged she had not checked the Kansas State Board of Nursing to ensure LN B had a current, active nursing license. The operator failed to ensure newly hired employee records contained evidence of licensure, registration, and certification for one of five newly hired staff that required specialized education and training.	S5258		
S5265 SS=E	26-42-205 (a) (1) Medication Self Administration Assessment (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced	S5265		

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S5265	Continued From page 22 by: KAR 26-42-205 (a)(1) The facility reported a census of eight Residents (R). The sample included 3 residents. Based on observation, interview, and record review for 2 (R615 and R616) of 3 residents who self-injected their insulin, the operator failed to ensure a Licensed Nurse (LN) assessed the resident to ensure they was able to self-inject their insulin safely and correctly or check their own blood sugar via glucometer if applicable. Findings included: - Review of R615's medical record revealed the resident moved into the facility on 03/16/22 with a diagnosis of diabetes. R615's "Functional Capacity Screen" dated 03/16/22 identified the resident was unable to complete the task of managing her own medications or medical treatments. R615's 'Negotiated Service Agreement" dated 03/17/22 identified staff would provide supervised Nursing services for management of her medications. It did not identify that the CMA would prepare and dial the resident's insulin pens and the resident would self inject. R615's "Health Service Plan" dated 03/16/22 identified staff to administer medication, and resident administers her insulin. Review of the resident's medical record did not include an assessment for the resident to be able to self inject her insulin Observation on 06/15/22 at 9:17 AM "Certified	S5265		

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Medication Aide" (CMA) C prepared the residents insulin according to physician's orders and went to the resident's room to give. Staff assisted the resident to sit on the side of the bed. Staff took an alcohol pad and wiped and area on the resident's left abdomen. CMA C then showed the resident the Levemir pen and the predialed amount of insulin and then held the pen above the resident's skin and told the resident to push the pen into her skin and push down on the plunger. With staff holding the pen, the resident pushed down on the pen, so it went into her skin and then continued to push down on the plunger. Staff then took the Humalog surveyor asked if the resident could self-inject without the staff supporting the pen. Staff then handed the resident the pen and she pushed it into her skin and staff then helped her steady it while she pushed down the plunger.

On 06/14/22 at 9:20 AM CMA C reported if a resident had insulin, they must inject it themselves. The CMA would get it all ready, dial it to the ordered dose, and then the resident injected it.

On 06/14/22 at 12:06 PM "Certified Medication Aide" (CMA) D reported staff were to get the resident's insulin pen ready, dialed it to the correct dose, and then assisted her with it and she pushed the button herself to inject it.

On 06/14/22 at 9:25 AM LN B confirmed CMA staff should be handing the resident the insulin pen and the resident should be able to do the rest after that.

On 06/15/22 at 3:55 PM LN B reported she had not completed an assessment on R615 to ensure she could safely and accurately self inject her

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S5265	Continued From page 24	S5265		

insulin.

The operator failed to ensure the Licensed Nurse completed a Self-administration assessment to identify the resident could independently self-inject her insulin before initiating self-injection

- Review of R616 revealed she moved into the facility on 06/02/22 with a diagnosis if type two diabetes.

R616's "Functional Capacity Screen" (FCS) dated 06/02/22 identified she needed supervision with management of her medications and physical assistance with her medical treatments.

R616's Negotiated Service Agreement" dated 06/02/22 identified staff provided supervised nursing services for management of medications and medical treatments.

R616's "Health Service Plan" dated 06/2/22 revealed the resident administered her own medications, staff will assist to administer her insulin pen and monitor blood sugars.

Review of R616's assessment for "Self Administration of Medications" failed to include an assessment for the resident's ability to check her own blood sugar via glucometer and failed to include her ability to safely and accurately self-inject her insulin.

On 06/14 at 12:06 PM "Certified Medication Aide" (CMA) D reported the resident managed all of her own medications including checking her blood sugars and administering her own insulin.

On 06/14/22 at 12:52 PM CMA C reported the resident took all her own medications including

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S5265	Continued From page 25 her insulin and blood sugars. On 06/15/22 at 03:52 PM LN B acknowledged the assessment for R616 to administer hew own medications did not include verification that she assessed the resident to administer safely and accurately hew own insulin and check her own blood sugars. The operator failed to ensure the LN completed a Self-administration assessment to identify the resident could independently perform the function of checking her blood sugar and completing the process of administering her insulin via "Flexpen" before doing so.	S5265		
S5300 SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home 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 home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced	S5300		

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by:
KAR 26-42-205 (d)

The facility reported a census of eight residents (R). The sample included 3 residents. Based on observation, interview and record review the Operator failed to ensure staff administered medications according to standards of practice for two (R614 and R615) of three sampled residents.

Findings included:

- Review of R614's medical record revealed she moved into the facility on 02/01/22 with diagnoses of anxiety, depression, pain, and hypertension.

R614's "Functional Capacity Screen" dated 06/14/22 revealed the resident was unable to manage her medications and medical treatments.

R614's "Negotiated Service Agreement" identified the facility would provide supervised nursing services related to medication administration.

R614's "Health Service Plan" revealed staff would administer the resident's medications.

The residents record included the following medical care providers orders:
05/24/22: Lorazepam (antianxiety) 0.5 milligrams (mg) every 4 hours as needed (PRN)for restlessness/anxiety/agitation.
03/29/22: Tylenol 500 mg tablet, take 2 tablets every 4 hours as needed for pain.

Review of the Resident's June 2022 "Medication Administration Record" (MAR) revealed the following:

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S5300	Continued From page 27 1. On 06/08/22 a CMA administered the PRN Lorazepam for restlessness/agitation. On 06/09/22 and 06/10/22 a CMA administered the PRN lorazepam for restlessness/anxiety. The record lacked evidence the CMA contacted the nurse to assess the resident prior to the administration of medication that lacked a specific reason for giving. The CMA staff also failed to follow up on the results (effectiveness) of the medication administered. 2. On 06/10/2022 at 05:00 PM staff failed to document the administration of the resident's Risperidone (an antipsychotic), Senokot, and Metoprolol (antihypertensive). Observation on 06/15/22 at 10:15 AM with Certified Medication Aide (CMA) C of the R614's medication cards revealed her Risperidone, Senokot, and Metoprolol were still in the card for 06/10/22, and had not been administered as ordered. Interview on 10:15 AM CMA C stated when there is a blank on the MAR it is her understanding that the medication was not administered, or the task was not completed. CMA C confirmed the resident did not get her medication on the 10th of June at 05:00 PM as ordered. On 06/15/22 at 10:25 AM Certified Medication Aide D reported staff would assess if a resident showed symptoms of pain such as wincing, grimacing, moaning, or stating they were in pain they could give the PRN medication such as Tylenol without calling the nurse. If the resident had a PRN narcotic staff were supposed to call the nurse before giving it. CMA D stated they did not need to contact the nurse before giving a PRN Lorazepam.	S5300		

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S5300	Continued From page 28 On 06/15/22 at 03:07 PM Licensed Nurse B confirmed they provided education for different staff who have had medication errors. She also confirmed staff needed to document if the PRN medication was effective or not. Review of the Kansas Certified Medication Aide Curriculum dated 2011 revealed "PRN-to be given whenever necessary. Ordering practitioners may write a PRN order for a medication or treatment. The order must contain specific parameters for implementing the order. The order must include the name of the medication, the dosage, and specific reasons for administration. An example would be: "Tylenol #3 every 6 hours for pain at incision site." If the resident requests medication for a headache, the Tylenol #3 should not be administered as the site of the pain is not covered by the order. Medication aides may not administer PRN medications which require an assessment. For example, a medication aide could not administer a PRN medication order for Ativan PRN for agitation. Standard of practice is for a nurse to assess the resident and decide the best method for reducing the resident's agitation. The medication aide would need to call a nurse for instructions. The operator failed to ensure R614's medications were administered according to the medical care providers written order and according to standards of practice." The operator failed to ensure staff administered R614's medications according to a medical providers written order and according to standards of practice. - Review of R615's medical record revealed she moved into the facility on 03/26/22 with diagnoses of diabetes mellitus and diarrhea.	S5300		

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S5300	Continued From page 29 R615's "Functional Capacity Screen" dated 03/16/22 revealed the resident was unable to manage her medications or medical treatments. R615's "Negotiated Service Agreement" dated 03/17/22 revealed the facility provided supervised nursing services for medication management. R615's "Health Service Plan" dated 03/16/22 revealed staff to administer (medications), resident administers insulin. The resident's record included the following orders: 03/22/22 - Tums chewable 500 (milligrams) every 2 hours as needed for GERD (gastro esophageal reflux disease) symptoms. The order did not identify what GERD symptoms to administer the medication for. 05/23/22 - Imodium A-D (antidiarrheal) 2 mg tablets initially then 1 tablet after each subsequent loose stool - maximum of 4 tablets in 24 hours. 05/26/22 - Insulin Lispro 100units/ml give an additional 2-3 units if blood glucose (BG) greater than 350. discontinued on 06/13/22 and changed to 2-3 units as needed if BG greater than 275. Review of the resident's June 2022 Medication Administration Record" (MAR) revealed the following. - 1. CMA staff gave the resident Imodium A-D 12 times without evidence of contacting the nurse to assess "loose stools" and the CMAs only followed up two times for effectiveness of the medication. 2. PRN insulin - On 06/01/22 at 08:00 PM the resident's BG read 365 with no evidence of contacting the nurse or administering insulin as ordered.	S5300		

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On 06/02/22 at 12:00 PM the BG read 378. The record lacked documentation that the nurse was contacted, and additional insulin was administered at 12:00 PM.
On 06/03/22 at 12:00 PM staff documented the administration of three units of insulin, but the residents BG was only 343. The record lacked CMA contacting the Nurse and should not have been administered as the resident's BG was not greater than 350.
On 06/08/22 staff documented a BG of 380 at 08:00 PM. The record lacked evidence of contacting the nurse and giving additional insulin as ordered.
3. The June MAR identified CMA staff administered the PRN tums 3 times. Staff documented the administration twice on the PRN administration record section of the MAR for "heart burn" and did not indicate that they called the nurse for direction regarding the symptoms the resident was expressing.

On 06/15/22 at 10:25 AM Certified Medication Aide D reported staff would assess if a resident showed symptoms of pain such as wincing, grimacing, moaning, or stating they were in pain they could give the PRN medication such as Tylenol without calling the nurse. If the resident had a PRN narcotic staff were supposed to call the nurse before giving it. CMA D stated they do not need to contact the nurse before giving a PRN Lorazepam.

On 06/15/22 at 03:07 PM Licensed Nurse B confirmed they had provided education for different staff who have had medication errors. She also confirmed staff needed to document if the PRN medication was effective or not.

Review of the Kansas Certified Medication Aide

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S5300	Continued From page 31 Curriculum dated 2011 revealed "PRN-to be given whenever necessary. Ordering practitioners may write a PRN order for a medication or treatment. The order must contain specific parameters for implementing the order. The order must include the name of the medication, the dosage, and specific reasons for administration. An example would be: "Tylenol #3 every 6 hours for pain at incision site." If the resident requests medication for a headache, the Tylenol #3 should not be administered as the site of the pain is not covered by the order. Medication aides may not administer PRN medications which require an assessment. For example, a medication aide could not administer a PRN medication order for Ativan PRN for agitation. Standard of practice is for a nurse to assess the resident and decide the best method for reducing the resident's agitation. The medication aide would need to call a nurse for instructions. The operator failed to ensure R614's medications were administered according to the medical care providers written order and according to standards of practice." The operator failed to ensure staff administered R614's medications according to a medical providers written order and according to standards of practice.	S5300		
S5302 SS=E	26-42-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S5302		

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S5302	Continued From page 32 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(4) The facility reported a census of eight residents. Based on interview and record review for three of three certified medications aide employee files, the operator failed to ensure the delegated nursing procedure for the dialing of insulin pens for each "Certified Medication Aide" under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included: - Review of three newly hired "Certified Medication Aide" (CMA) employee records for CMA F, CMA H, and CMA I did not have evidence of a licensed nurse delegation for preparation and dialing of insulin pens for residents to self inject. On 06/14/22 at 11:55 AM Administrative staff J acknowledged the facility did not have evidence of a Licensed Nurse delegating the procedure of preparing and dialing a resident's insulin pen. The operator failed to ensure Certified Medication Aides were properly trained on the procedure for dialing and set up of an insulin pen for the residents to self-inject.	S5302		
S5315 SS=E	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy	S5315		

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provider and with federal and state laws and regulations.
(1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals.
(2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides.
(3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home.
(4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.

This REQUIREMENT is not met as evidenced by:
KAR 26-42-205 (h)(1)(4)

The facility reported a census of eight residents. Based on observation and interview the operator failed to ensure controlled medications were securely and properly stored in accordance with manufacturer's recommendations and win accordance with federal and state laws and

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regulations. This failure included the failure to store controlled medications managed by the home in separately locked compartment within a locked medication room cabinet to where only licensed nurses and medication aides had access to the medications. The facility also failed to ensure medications were not administered beyond the manufacturer's recommended date of expiration by the failure to date insulin pens when staff initiate use.

Findings included:

- On 06/14/22 at 09:20 AM with Certified Medication Aide (CMA) C observation of where staff stored medications revealed a baggie with Resident (R) 615's name on it and it contained two insulin pens. Neither pen had the resident's name on them, and one pen ("Basaglar Kwick Pen") did not include a date staff-initiated use of the pen.

On 06/14/22 at 09:21 AM CMA C stated she did not know when the one insulin pen was opened and acknowledged the pen should have had the date staff started to use it on the pen.

Review of the "Basaglar KwickPen" storage use revealed for pens in-use "... Throw away the Pen you are using after 28 days, even if it still has insulin left in it."

The operator failed to ensure all insulin pens were dated to ensure staff did not use medications beyond the manufacturer's recommended date of expiration.

- On 06/14/22 at 9:22 AM CMA C reported staff stored the overflow narcotics in the nurse's office, which is kept locked, in the locked cabinet so that

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S5315	Continued From page 35 way they are double locked. Observations on 06/15/22 at 10:35 AM the nurse's office door was open and the file cabinet was unlocked. In the bottom drawer of the file cabinet was a plastic container with the following medications in it: four boxes with bottles of "Roxanol" (morphine sulfate, a narcotic pain medication) in each one, a two cards of lorazepam (antianxiety medication) 0.5 milligrams (mg) with 30 tablets in each one and another card of lorazepam, 0.5 mg with 14 half tablets. On 06/15/22 at 10:47 AM Licensed Nurse B acknowledged that when her office door is open the narcotics in the file cabinet are not double locked. She also acknowledged that if the file cabinet is unlocked the medications would be accessible to anyone, including those who are not a nurse or a certified medication aide. The operator failed to ensure controlled medications were securely and properly stored according to federal and state laws.	S5315		
S5335 SS=E	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced	S5335		

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S5335	Continued From page 36 by: KAR 28-39-437 (a) The facility reported a census of eight residents. Based on observation and interview the operator failed to ensure staff secured all chemicals to maintain the safety of all residents and the public. Findings included: - Review of the resident roster on 06/14/22 revealed the facility had a census of eight residents with six of the eight residents identified as having impaired cognition. During initial tour on 06/14/22 at 08:12 AM revealed the following unsecured chemicals: In the hall just past the entryway revealed a closet with an unlocked sliding door which contained a carpet cleaning machine and other cleaning supplies. On the top shelf in the closet on the edge sat a bottle of "Oxy" carpet cleaner and a spray bottle of "Resolve Pet Cleaner" which both had warning labels on them that included to "keep out of reach of children". In the unlocked laundry area on the counter by the sink sat a container of "Tide Pods" and a box of dryer sheets, both had warning labels on them that included "keep out of reach of children". In the kitchen in the unlocked cabinet under the sink contained a plastic container of "Cascade Pods", "Cascade Liquid Dishwasher Detergent", a bottle of glass stovetop cleaner, and a container of disinfectant wipes. On 06/14/22 at 09:00 AM Operator A confirmed the chemicals should have been locked up.	S5335		

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S5335	Continued From page 37 The operator failed to ensure staff kept chemicals safely secured to maintain safety for all residents and the public.	S5335		
S9999	Final Observations KAR 26-42-103 (a) (a) The administrator or operator of each home plus shall ensure the provision of orientation to new employees and regular in-service education for all employees to ensure the provision of orientation to new employees and regular in-service education for all employees to ensure that the services provided assist residents to attain and maintain their individuality, autonomy, dignity, independence, and ability to make choices in a home environment. The facility reported a census of eight residents. Based on interview the operator failed to ensure staff provided services and assisted residents in ways to ensure they maintained their dignity. Findings included: - Review of an anonymous complaint filed with the Kansas Department for Aging and Disability Services revealed a Certified Medication Aide (CMA) had family and staff complaints about another CMA and how he/she talked to residents. The anonymous complainant reported staff heard the other CMA curse at residents, be condescending in how he/she talked to them, and scolded residents who need help with activities of daily living (ADLs).	S9999		

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Review of the resident roster provided by the facility identified that six out of the eight residents had impaired cognition.

During a confidential interview, an unidentified resident stated that there was one staff member who sometimes spoke to her rudely but did not know the staff person's name.

During a confidential interview an unidentified employee reported CMA E was overheard cursing, being rude, and inappropriate with residents. The staff member reported a prior resident did not want CMA E to provide care to them because he/she was rude and abrupt with the resident. The staff member then reported he/she and others had reported these concerns to Operator A.

During a confidential interview an unidentified employee reported CMA E, a current employee, would refuse to give showers, was terribly rude to residents, and had a prior resident whose family did not want CMA E taking care of the resident anymore. This staff had also heard the CMA E curse at a resident. Staff reported Operator A was told multiple times about concerns with this employee.

During another confidential interview, an unidentified staff member reported CMA E was rude and not nice to the residents. A prior resident was afraid of CMA E and would not let him/her care for them. This staff member reported CMA E cussed at resident's before and did not treat them with respect or dignity. The staff member stated all of this was reported to Operator A, but the concerns continued to happen.

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S9999	Continued From page 39 On 06/15/22 at 10:47 AM during a discussion about staff treatment of residents and disciplinary warnings on treatment of residents, Operator A acknowledged he had heard concerns related to CMA E and how she talked to and treated residents. Operator A commented none of the complaints met the definition of abuse, so he did not know at what point to take action on the employee. Review of the "Orientation Checklist" provided by the facility included a review of "Resident Rights". Review of the "Resident Rights" provided by the facility revealed residents had the right to "be treated fairly, courteously and with dignity and respect by all staff." The operator failed to provide and implement education at orientation to new employees and regular in-service education for all employees to ensure services provided by facility staff were done in a manner to assist residents to attain and maintain their dignity while living in a home environment.	S9999		