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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey for the above named Home Plus facility conducted on 6/7,8,9/2022	S 000		
S5026 SS=D	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(1)(B) The facility reported a census of seven residents and the sample included 3 residents (R). Based on interview and record review the operator failed to ensure R200 was not subjected to neglect when direct care staff failed to follow the interventions as identified in the residents "Health Care Service Plan". Findings included: - Review of R200's medical record revealed he moved into the facility on 06/18/18 with diagnoses of dementia and cortical basal syndrome (degenerative nerve disease). The "Functional Capacity Screen" (FCS) dated	S5026		

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

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05/12/22 revealed the resident required physical assistance with all activities of daily living, had a risk for falls/unsteadiness, and had a score of 4 for cognition indicating the resident had impaired memory recall and overall cognitive status.

The "Negotiated Service Agreement" (NSA) dated 05/12/22 included physical assistance from staff for activities of daily living, and that the resident had a body alarm related to falls.

The "Health Care Service Plan" (HCSP) dated 06/08/21 included the following fall interventions: bell in bathroom to alert staff when done, do not wake resident up to toilet, assist when indicates he needs to use the restroom. The HCSP included the following handwritten updated interventions: resident is not to be left unattended in the restroom (undated), 09/11/21 chair alarm, bed alarm and floor mat, and on 10/6/21 for staff to take all belongings needed into the bathroom when assisting the resident.

The "Health Care Service Plan" (HCSP) dated 05/12/22 included fall interventions to not wake the resident during the night to toilet, he cannot be left unattended in the bathroom, take all supplies in when taking resident to the bathroom, to use a gait belt as needed, remind resident to stand up slow, body alarm on at all times, use a chair pad alarm, and to use both alarms when in wheelchair and recliner.

Review of the "Fall Investigations" provided from Administrative/Licensed nurse between 01/01/22 and 05/12/22 included the following situation where staff failed to follow interventions that were initiated due to prior falls:
On 01/09/22 resident at dining room table and staff in the kitchen when heard alarm and saw

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resident on the floor. Intervention for staff to make sure wearing alarm correctly.
On 01/16/22 staff were in another room and the resident remained in the living room and alarm was not connected to the resident. Staff heard a thump and found resident on floor. Staff failed to ensure resident had both alarms on and activated.
On 01/20/22 staff left resident in the bathroom and heard a noise and found resident on the floor. Staff failed to remain with the resident while in the bathroom.
On 1/22/22 staff left resident alone in bathroom sitting on the toilet. Staff again failed to remain with the resident while in the bathroom.
On 02/17/22 (third fall of the day) staff pushed resident to the dining room table and the resident reached forward and fell. Staff failed to ensure body alarm is on and working.
On 02/20/22 staff left resident on the toilet alone and he fell. Staff failed again to remain with residents while in the bathroom.
On 03/18/22 resident fell out of bed again and staff were once again educated to ensure the resident's bed alarm was on and to increase visual checks while in bed.
On 04/19/22 the resident was alone in the bathroom and fell. Staff failed to stay with the resident while in the bathroom.
On 04/27/22 resident was in the recliner, stoop up, and fell. Staff failed to ensure alarm was in the resident's recliner.
On 04/29/22 Resident attempted to stand up from the recliner and fell. Staff failed to have the chair alarm on.
On 06/08/22 at 01:50 PM CMA B reported the care plan is where staff find what kind of care the resident needs and what they are supposed to do for them. CMA B stated the resident tried to get himself out of the recliner, so we must watch him

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S5026	Continued From page 3 closely. He had 2 alarms, which he sat on, and a tab alarm and staff tried to stay with him while doing cares, and they could not leave him alone in the bathroom. On 06/09/22 at 10:32 AM after reviewing the residents fall investigations Administrative staff/Licensed Nurse A confirmed the resident did have falls where staff failed to follow the residents health care service plan in making sure he was not left unattended in the bathroom and regarding making sure he had on his chair and tab alarms at all times. The operator failed to ensure the resident did not experience neglect when staff failed to follow R200's health care service plan.	S5026		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201 (C)(2) The facility reported a census of seven residents. The sample included three residents (R). Based on observation, interview and record review the	S5085		

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operator failed to ensure staff completed a screening to determine one (R100) of three resident's Functional Capacity following a significant change in condition as defined in K.A.R. 26-39-100.

Findings Included:

- Review of R100's medical record revealed she moved into the facility on 05/22/20 with diagnoses of dementia, senile degeneration of the brain, and spinal stenosis.

R100's "Functional Capacity Screen" (FCS) dated 05/22/21 identified the resident required physical assistance with bathing, supervision with dressing and was independent with toileting, transfers, mobility, and eating. The resident had cognitive impairment, had no bladder incontinence, and was not at risk for falls. It also identified the resident had impaired decision-making, wandered, and not at risk for falls/unsteadiness.

R100's FCS dated 05/22/22 identified as the annual FCS showed a significant change in the residents functional abilities. The resident now needed physical assistance with bathing, dressing, toileting, transfers, walking/mobility and supervision with eating. Staff also identified her as having bladder incontinence and at risk for falls/unsteadiness.

Review of the residents's "Notes" (nursing progress notes) revealed the following:

The "Notes" identified from 05/22/21 when the prior FCS was completed, to 11/16/21 when the resident had a noted decline in status and started on Hospice services she had seven falls.

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S5085	Continued From page 5 On 11/16/21 at 01:19 PM revealed "Change in condition Nurse Note -[name] visited with myself and [name] regarding resident- resident is on services with [home health] for Procrit injections and labs pertaining to edema- [Homehealth] discussed resident in IDG meeting- resident has been showing signs of decline- especially with weight loss, increased memory loss/confusion and mobility- resident has been using W/C (wheelchair) for primary mode of mobility and not ambulating with walker- has had several falls- APRN and this nurse had previously discussed this option for resident but APRN did not want to stop Procrit for enema- plan is to continue with Procrit- this nurse will visit with residents daughter to see if this is something she would like to proceed with". On 11/19/21 at 1:44 PM the"Notes" indicate staff admitted the resident to Hospice services. From 11/19/21 till the next FCS was completed on 05/22/22 the resident had seven more falls, with documentation that indicated the resident needed physical assistance with all activities of daily living and continues to decline in overall functional ability. Observation on 6/8/22 at 10:18 AM "Certified Medication Aide" (CMA) B went into the resident's room and asked her if she was ready to get up and resident nodded in agreement. CMA B then got socks out and put them on the resident. The resident raised her feet while staff put on her socks. CMA B then helped the resident to sit on the side of the bed and pulled the wheelchair closer to the bed. After sitting for a minute to gather her composure, CMA B put the resident's shoes on her and asked the resident to stand to get into the wheelchair. The reasident reached for the wheelchair and rubbed her right knee	S5085		

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S5085	Continued From page 6 saying "my dang leg is hurting". R100 then stood up as CMA B stood on her left side and held her under her left arm to help her into the chair. When resident stood up there was not an alarm that sounded and did not see one on the bed after she got into the wheelchair. CMA B then pushed the resident into the bathroom and up to the grab bar by the toilet. The resident reached for the grab bar and CMA B assisted the resident to stand up from behind. CMA proceeded to assist the residnet with grooming care, dressing, and provided peri-care when she finished using the bathroom. Staff then pushed the resident by the sink so that the resident could finish her peronal grooming for the morning. The resident was able to help with the process of getting dressed and up for the day but CMA B had to provide physical assistance with all aspects of cares. On 06/08/2022 at 02:10 PM, CMA B reported the resident takes a lot of cueing for "Activities of Daily Living" (ADL)s. R100 can do quite a bit but just needs guidance and gettinf things started. When R100 first came to the facility she wandered throughout the facility and walked a lot but she doesn't do that anymore. She had a lot of knee and hip pain and think that is part of why she doesn't walk so much anymore. CMA B comfirmed the resident had declined since moving into the facility. The operator failed to insure designated staff completed a Functional Capacity Screen when R100 had a significant change in status.	S5085		
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home	S5155		

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S5155	Continued From page 7 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 seven residents. The sample included three residents. Based on observation, interview, and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of two (R100 and R200) of three sampled residents in accordance with their "Functional Capacity Screen" and their "Negotiated Service Agreement" related to falls. Findings included: - Review of R100's medical record revealed she moved into the facility on 05/22/20 with diagnoses of dementia, senile degeneration of the brain, and spinal stenosis. R100's "Functional Capacity Screen" (FCS) dated 05/22/21 revealed the resident was independent in toileting, transfers and walking/mobility and had a score of four in cognition, identifying the resident had impaired cognition. It identified the resident wandered but was not at risk for falls or unsteadiness.	S5155		

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S5155	Continued From page 8 The "Negotiated Service Agreement" (NSA) dated 05/22/21 identified the resident independent with transfers, toileting, walking/mobility, had impaired memory recall with impaired cognition. It did not identify the resident at risk for falls. The "Health Care Service Plan" (HCSP) dated 05/22/21 included an update on 11/08/21 to have nonskid mat in chair and included an undated intervention of having a body alarm on resident. Review of the resident's "Notes" from 07/05/21 to 5/22/22 when the current NSA and HCSP were completed, the resident had 17 falls. Review of the "Fall Investigations" provided by Administrative/Licensed Nursing Staff A revealed the resident had six falls had no new "actions implemented to prevent future falls" and four falls included interventions on reminding or encouraging the resident to use her walker or not pet the dog. Other interventions included for staff to "watch resident more closely when in the restroom", the use of nonskid material in chair, use of a body alarm, and a floor mat. Falls dated 01/25/22 and 02/25/22 did not have fall investigations completed to identify possible causes of the fall or "actions implemented to prevent future falls". The Licensed Nurse failed to update the resident's HCSP to include the need to "observe the resident more closely when in the bathroom and did not include "safety checks" to be conducted. The Licensed nurse also failed to ensure the interventions were appropriate due to the resident's impaired memory recall ability and overall impaired cognition.	S5155		

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Observation on 06/08/22 at 09:34 AM the resident lay in bed with the bed in lowest position, fall mat on the floor beside the bed, and a tab alarm on the wheelchair.

On 06/08/22 at 2:10 PM "Certified Medication Aide" (CMA) B reported she looked at the care plan to know what kind of cares she needed to provide residents. She confirmed the resident was at risk for falls and the resident had a tab alarm on, had a low bed and a mat on the floor.

On 06/09/22 at 07:14 AM CMA D confirmed the resident had a risk for falls and staff needed to have the resident's alarm on when in the chair, had a floor mat by the bed and the bed needed to be in the lowest position.

On 06/09/22 at 10:32 AM after reviewing R100's fall investigations with Administrative/Licensed Nurse staff A, she confirmed the resident had a fall after the nonskid product was to be in the chair and it wasn't on. She also acknowledged the need to make sure interventions were appropriate for residents who had dementia.

Administrative/Licensed Nurse staff A failed to ensure all falls were thoroughly investigated, appropriate interventions were identified and the HCSP was updated with interventions to reduce risk of future falls as needed.

- Review of R200's medical record revealed he moved into the facility on 06/18/18 with diagnoses of dementia and cortical basal syndrome (degenerative nerve disease).

The "Functional Capacity Screen" (FCS) dated 05/12/22 revealed the resident required physical assistance with all activities of daily living, had a

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risk for falls/unsteadiness, and had a score of 4 for cognition indicating the resident had impaired memory recall and overall cognitive status.

The prior FCS dated 06/08/21 also identified the resident had cognitive impairment and had a risk for falls/unsteadiness.

The "Negotiated Service Agreement" (NSA) dated 05/12/22 included physical assistance from staff for activities of daily living, and that the resident had a body alarm related to falls.

The prior NSA dated 06/08/21 identified the resident at risk for falls and that he needed physical assistance of 1 staff for activities of daily living.

The "Health Care Service Plan" (HCSP) dated 06/08/21 included the following fall interventions: bell in bathroom to alert staff when done, do not wake resident up to toilet, assist when indicates he needs to use the restroom. The HCSP included the following handwritten updated: resident is not to be left unattended in the restroom (undated), 09/11/21 chair alarm, bed alarm and floor mat, and on 10/6/21 for staff to take all belongings needed into the bathroom when assisting the resident,

The "Health Care Service Plan" (HCSP) dated 5/12/22 included fall interventions to not wake the resident during the night to toilet, he could not be left unattended in the bathroom, take all supplies in when taking resident to the bathroom, use a chair pad alarm, and to use both alarms when in wheelchair and recliner.

Review of the resident's "Notes" from 06/08/21 to 05/12/22 (time between prior and current FCS,

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NSA and HCSP) the resident had a total of 40 falls and the health care service plan only included 4 updates with new interventions. The "Notes" included the following interventions: continue monitoring resident's status and report any changes to nursing team, bedroom door to remain ajar for frequent visual checks, fall mat and bed alarm, body alarm to always be in place, reminding care giver to make sure his chair alarm is active when sitting in recliner. The licensed nurse failed to update the residents HCSP to include keeping the bedroom door ajar for frequent visual checks, and to toilet resident"frequently".

Review of the resident's "Notes from 05/12/22 to current revealed the resident had 4 falls and the HCSP initiated on 05/12/22 did not included any additional revisions for fall interventions. The "Notes included that staff would look for a different type of alarm since resident could unhook current body alarm.

Review of the Fall investigations between 01/01/22 and 05/12/22 provided by Administrative/Licensed nurse revealed the following: Four falls were reminders for staff to not leave the resident alone while in the restroom, five falls included the intervention to discuss different placement due to resident safety and decline in status, and 7 falls included interventions related staf making sure alarms were on appropriately and working. One fall was not thouroughly investigated (2/17/22) and 3 falls identified to continue with current HCSP.

Observation on 06/08/22 at 09:38 AM revealed the resident's bed was a few inches off the floor, had a mat on the floor beside the bed and there was a pressure pad in the bed. The resident also

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had a scoop mattress on the bed. "Certified Medication Aide" (CMA) B went in to get the resident up for the day. As staff assisted the resident to stand up the bed alarm sounded. CMA B gathered his razor and other items and then pushed the resident to the bathroom in his wheelchair but did not put any pedals on the wheelchair. CMA B assisted the onto the toilet, completed some of his morning cares and then helped him back into the wheelchair. She then moved the resident in front of the sink to complete oral care and then brought the resident out to the recliner in the TV area. CMA B put the char alarm in the recliner and then helped the resident to sit in the recliner and elevated the foot of the recliner. When staff pushed the resident he did not have pedals on his wheelchair.

Observation on 06/09/22 at 07:04 AM revealed the resident lay in bed in the lowest position, mat on floor, alarms on bed, and observed anti-tippers on the back of his wheelchair.

Observation on 06/08/22 at 01:52 PM the resident sat in his recliner and had taken off the lap blanket and was moving his feet back and forth. CMA B went over to the resident and sat with him for a little while and then took the resident to bed because he indicated that was what he wanted to do.

On 06/08/22 at 01:50 PM CMA B reported the care plan is where staff find what kind of care the resident needs and what they are supposed to do for them. CMA B stated the resident tried to get himself out of the recliner, so we must watch him closely. He had 2 alarms; one that he sat on and a tab alarm and staff tried to stay with him while doing cares. At one point he fell a lot, would just get up and go out of nowhere so staff could not

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(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
S5155	Continued From page 13 leave him alone. He used to ring a bell when he was done in the bathroom, but he started to get up himself and falling so we stay with him. On 06/08/22 at 10:07 PM CMA C reported the resident had a chair alarm, a bed alarm, and he was to have them both on at all times. She stated she checked on him about every 15 minutes because can fall a lot. Staff kept the feet of the recliner elevated and if he started to get fidgety, we tried to figure out if he wanted to go to bed or needed to use the bathroom. On 06/09/22 at 10:32 AM after reviewing the residents fall investigations when Administrative staff/Licensed Nurse A confirmed the HCSP did not include that staff were to have foot pedals on the resident's wheelchair when pushing him and confirmed that staff did not follow through with interventions that were planned for the resident including always having alarms on and not leaving the resident unattended in the bathroom. The operator failed to ensure the Licensed nurse provided and coordinated the necessary health care services related to his risk for falls as identified in the FCS and NSA for R200.	S5155		
S5315 SS=F	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 provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087095	A. BUILDING: _____ B. WING _____	06/09/2022

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S5315	Continued From page 14 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) The facility reported a census of 7 residents. Based on observation and interview the operator failed to ensure non-controlled medications managed by the home were stored in a locked medications room, cabinet, or medication cart where licensed nurses and medications aides were the only ones with access to stored medications. Findings included:	S5315		

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S5315	Continued From page 15 - During initial tour on 06/07/22 at 02:42 PM surveyor observed 2 boxes of Procrit (medication to treat anemia) sitting on a shelf on the door of the refrigerator. Administrative Staff/Licensed Nurse A stated the medication boxes were to be kept in the lock box in the refrigerator. Staff A took the medications out of the door, got the lock box out and put the medications in the lock box. Review of the "Storage of Medication policy dated 10/22/13 revealed medication that required refrigeration should be store in the refrigerator in a locked box. No medications are to be stored in the door of the refrigerator. The operator failed to ensure all medications the facility managed were stored in the locked medication cabinet.	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 by: KAR 28-39-437 (a) The facility reported a census of seven residents. Based on observation and interview the operator	S5335		

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S5335	Continued From page 16 failed to ensure staff secured all chemicals to maintain the safety of all residents and the public. Findings included: - During initial tour on 06/07/22 at 02:10 PM in the west communal restroom behind the door was a large cabinet unit with upper and lower cabinets and drawers. In the lower unlocked cabinets were the following items: 2 spray cans of Brody Disinfectant spray, spray bottle of glass cleaner, spray bottle of Glitz and a no rinse sanitizer. Each of the items had warning labels and directions to keep out of reach of children. On 06/07/22 at 02:20 PM Certified Medication Aide B confirmed the chemicals were not to be in the unlocked cabinet and put them in the unlocked cabinet under the kitchen sink. On 06/07/22 at 02:41 PM Administrative Staff/Licensed Nurse A confirmed all chemicals needed to be kept locked and out of reach of residents. Review of the "Safety Procedures" policy dated 10/22/13 directed staff to "never leave chemicals or cleaning products unattended in a location accessible by residents". The operator failed to ensure staff kept chemicals safely secured to maintain safety for all residents and the public.	S5335		