STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B023016	A. BUILDING: _____ B. WING _____	03/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE HAVEN VILLAGE	1701 RESEARCH PARK DRIVE LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named home plus facility conducted on 03/14/22, 03/15/22, 03/16/22, 03/17/22 and 03/21/22.	S 000		
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 26-42-201 (c) (1) The census equaled 11 residents. The sample included 3 residents. Based on record review and interview the facility failed to ensure designated facility staff conducted a screening at least once every 365 day to determine each resident's functional capacity for Residents (R) 314 and 434. Findings included: - R 314's "Medical Record" revealed she admitted to the facility on 07/23/20 with diagnoses of dementia, constipation, atrial fibrillation, and depression. The "Functional Capacity Screen" (FCS) dated	S5085		

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

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S5085	Continued From page 1 07/23/20 recorded the resident required physical assistance with bathing, dressing, toileting, transfers, walk/mobility, was unable to manage medications and treatments, occasionally incontinent, had impaired short-term memory and memory recall, usually understandable/ understands, was a fall risk, and had impaired vision. R 314's "Medical record" lacked completion of a FCS since admission. R 434's "Medical Record" revealed she admitted to the facility on 08/27/19 with diagnoses of Parkinson's Disease, hypertension, and atrial fibrillation. The "Functional Capacity Screen" (FCS) dated 08/01/20 recorded the resident required physical assistance with bathing, dressing, toileting, transfers, walk/mobility, supervision with eating, was unable to manage medications and treatments, frequently incontinent, had impaired short-term memory, memory recall and impaired decision making, understandable/ understands, and was a fall risk. R 434's "Medical Record" lacked completion of a FCS since 08/01/20. The facility's "Functional Capacity Screen" policy dated 01/2019 recorded, "[facility name] completes a Functional Capacity Screen on all residents on or prior to admission to the home, with each significant change, and at least every 365 days." Interview on 03/14/22 at 4:48 PM with Director of Nursing/ Licensed Nurse A confirmed the record lacked a FCS every 365 days for R 314 and R	S5085		

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S5085	Continued From page 2 434. The facility failed to ensure designated facility staff conducted a screening at least once every 365 days to determine each resident's functional capacity for R 314 and 434.	S5085		
S5230 SS=D	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 by: K.A.R 26-42-207 (c) The census totaled 11 residents. The sample included 3 residents and review of 5 newly hired employees. Based on record review and interview for 3 Residents (R) 314, 434 and 677, the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines. Findings included:	S5230		

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S5230	Continued From page 3 - R 314's "Health Record" revealed she admitted to the facility on 07/23/20 and the record lacked evidence of an annual TB questionnaire since 01/19/21. R 434's "Health Record" revealed she admitted to the facility on 08/27/19 and the record lacked evidence of an annual TB questionnaire since 01/19/21. R 677's "Health Record" revealed she admitted to the facility on 07/19/16 and the record lacked evidence of an annual TB questionnaire since 01/19/21. Interview on 03/14/22 with Director of Nursing/ Licensed Nurse A confirmed resident R 314, 434 and 677 did not receive an annual TB questionnaire since 01/19/21. The facility adopted the KDADS TB guidelines as guidance for their TB policy. The facility failed to complete an annual TB questionnaire for R 314, 434, and 677, which had the potential to affect all residents.	S5230		
S5335 SS=F	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	S5335		

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S5335	Continued From page 4 fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437 (a) The census equaled 11 residents. The sample included 3 residents. Based on record review, observation, and interview, the facility failed to keep cleaning chemicals in a locked, secured area, posing a potential safety hazard. Findings included: - On 03/14/22, Director of Nursing/ Licensed Nurse A provided a "Resident Roster" of 11 residents and all residents had impaired cognitive abilities. During the initial tour on 03/14/22 at 2:45 PM with Director of Nursing/Licensed Nurse A, observation revealed an unlocked cabinet under the kitchen sink. The cabinet contained the following chemicals: 1 bottle Drano Max Gel 42 ounce (oz), 1 Stainless Steel Cleaner and Polish 15 oz, 1 Urine Gone Cleaner 24 oz, 1 Glass Cleaner: 32 oz, 1 Goo Gone 12 oz, 1 All- Purpose cleaner 32 oz, 5 bottles Lysol 19 oz (eye irritant), 1 Weather Defense Guard 10 oz, 1 Comet Deodorizing Cleanser 21 oz, 1 Dishwasher Gel 75 oz, 2 Goof Off 16 oz, 1 Easy Off 14.5 oz and 1 can Raid 18 oz. All the listed containers included a warning label on them. During the initial tour on 03/14/22 at 3:10 PM with Director of Nursing /Licensed Nurse A, observation revealed an unlocked closet in the hallway next to resident rooms. The closet contained the following chemicals:	S5335		

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S5335	Continued From page 5 5 cans of paint (1 gallon) and 1 Glass Cleaner 32 oz. All the listed containers included a warning label on them. Interview on 03/14/22 at 2:45 PM with Director of Nursing/ Licensed Nurse A confirmed cabinet under sink should be locked, but the childproof lock was broken on the left side of the cabinet. Interview on 03/14/22 at 3:10 PM with Director of Nursing/ Licensed Nurse A confirmed the hallway closet should be locked at all times. The facility's "[Facility Name] Care Chemical Storage Policy" (no date) recorded, "Chemicals MUST be locked up at all times. [Facility Name] Managers will conduct periodic cleanouts to prevent accumulation unnecessary chemicals." The facility failed to keep cleaning chemicals in a locked secured area, posing a potential safety hazard.	S5335		