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	N023017	A. BUILDING: _____ B. WING _____	C 08/25/2021

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THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaint # 164579 at the above named assisted living facility conducted on 8-18,23,24,25/2021.	S 000		
S3045 SS=F	26-41-101 (j) Emergency Telephone (j) Emergency telephone. Each administrator or operator shall ensure that the residents and employees have access to a telephone for emergency use at no cost. The administrator or operator shall ensure that the names and telephone numbers of persons or places commonly required in emergencies are posted adjacent to this telephone. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(j) The facility reported a census of 35 residents. The sample included 3 resident's. Based on observations, interview and record review the operator failed to ensure the cottages had a working telephone for resident and staff emergency use. This failure effected all 4 residents that lived in the cottages. Findings included: - During initial tour on 8-18-21 of the cottages observations lacked evidence that there was a phone on the unit for staff, residents, or visitors to use in the case of an emergency. During an interview on 8-24-21 at 7:09 AM certified nursing assistant B confirmed there was	S3045		

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

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S3045	Continued From page 1 not a phone in the cottages for residents, visitors, or staff to use in the case of an emergency. Staff B stated she had to use her personal cell phone if she had an emergency or needed something in the cottages. The operator failed to ensure the cottages had a phone available for residents and staff for emergency use.	S3045		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (i) The facility reported a census of 35 residents. The sample included 3 resident's. Based on interview and record review the operator/licensed nurse failed to ensure a licensed nurse assessed 1 (#100) of 3 sampled residents after an unwitnessed fall in which the resident complained of back pain and had increased negative behaviors when staff attempted to provide cares to ensure the resident did not have any underlying injuries post fall. Findings included: - Review of resident #100's medical record revealed the resident moved into the facility on	S3171		

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S3171	Continued From page 2 7-19-21 with diagnosis of degenerative dementia. Review of the resident's functional capacity screen dated 7-19-21 revealed the resident required physical assistance with all activities of daily living including walking/mobility, had bladder incontinence, impaired cognition and had a current problem / risk for falls and unsteadiness. Review of the residents negotiated service agreement/ health care service plan (NSA/HCSP) dated 7-19-21 revealed the resident required supervision daily for safety due to mental confusion and/or mobility impairment. It also directed staff to supervise the resident during the day and throughout the night due to mental status/confusion and he is a fall risk. The NSA/HCSP revealed the resident required 1 person assistance with transfers into his wheelchair and he required assistance to propel his wheelchair. Review of a fall investigation report that is not dated or signed by a nurse revealed resident #100 had an unwitnessed fall on 7-19-21 at 10:12 PM. It revealed certified nursing staff found the resident lying on his right side in the bathroom with no apparent injuries. The resident was unable to state what happened or if he was in pain. It also revealed "the aides said he said his back hurt. It revealed at 10:20 PM staff notified operator/licensed nurse G of the fall and were told it was OK to pick the resident up off the floor and monitor him. The investigation included a physician fax completed by certified medication aide E that the resident had an unwitnessed fall in the bathroom with no apparent injury, but failed to notify the physician the certified nursing assistance heard the resident say his back hurt. The report included a statement from certified	S3171		

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S3171	Continued From page 3	S3171		

nursing assistant F which revealed they heard a loud crash and when they got in the room the resident was on the bathroom floor. It revealed the resident reported he had back pain and then staff called the certified medication aid E who then called the operator/licensed nurse G. Review of a written statement fro certified nursing assistance H identified the resident also complained of his back hurting.

Review of the shift report notes revealed the following: (starts with night shift, then days, then evenings)
7-20-21 on night shift the resident was up at 2:30 AM very confused to use the restroom and complained of his back hurting and was agitated. On the evening shift staff noted the resident complained of back pain and was agitated.
7-21-21 on night shift staff noted the resident was angry and refused cares. On evening shift the resident went to bed at 11:30 PM and required assistance of 2 staff.
7-22-21 on the night shift staff again noted the resident required assistance of 2 staff.
The shift reports lacked any addition notes that the nurse was notified of the resident's pain.

Review of the resident's nurses notes revealed the following:
7-19-21 resident moved into the facility at 5:30 PM accompanied with his wife and was able to walk into the facility with the use of his walker. The resident was alert and oriented to self, denied pain and was able to voice needs/concerns clearly to staff. The staff noted the resident had an unsteady gait and is a fall risk.
7-30-21 at 10;00 am -the resident had a telahealth appointment in regards to the resident's back pain associated with a previous

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S3171	Continued From page 4 fall. the physician ordered a stat L-spine x-ray and Tramadol (pain medication) every 8 hours as needed for pain. (11 days after the resident had his fall) 7-30-21 at 12:40 PM -the x-ray tech arrived and the resident refused to allow to have the x-ray done. The resident record lacked a licensed nurse physical assessment or follow up assessments, after the resident had an unwitnessed fall the evening on 7-19-21 in which the resident complained of back pain and continued to complain of back pain the next day and expressed an increase in agitation and aggression when staff attempted to provide cares. The operator/licensed nurse failed to ensure a licensed nurse assessed the resident after he had a fall and continued to complain of back pain and had symptoms of increased agitation/aggression with cares which could be associated with pain according in accordance to acceptable standards of practice.	S3171		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility 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:	S3200		

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S3200	Continued From page 5 (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) The facility reported a census of 35 residents. The sample included 3 residents. Based on interview and record review the operator/RN failed to ensure facility staff administered medications for 1 (#100) of 3 sampled residents whom the facility was responsible for administering medications, according the medical care providers written order and professional standards of practice. Findings included: - Review of resident #100's medical record revealed the resident moved into the facility on 7-19-21 with diagnosis of degenerative dementia. Review of the resident's functional capacity screens dated 7-19-21 and 8-1-21 revealed the resident required physical assistance with all activities of daily living and could not manage his own medications and medical treatment. Review of the residents negotiated service agreement/ health care service plan (NSA/HCSP) dated 7-19-21 revealed the resident required supervision daily for safety due to mental	S3200		

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S3200	Continued From page 6	S3200		

confusion and/or mobility impairment. It also revealed certified medication aides or a licensed nurse was responsible for the administration of the resident's medications and the ordering of his medications.

Review of the resident's physician orders revealed operator/licensed nurse G sent a fax to the physician on 8-6-21 at 10:07 AM that revealed the resident's family had requested the Tramadol to be scheduled as the resident is unable to ask for it as needed. It revealed the Acetaminophen had been administered multiple times but did not seem to be effective.

The record included a response to the above fax that was noted by the operator/licensed nurse with a written order to give Tramadol 50 milligrams (mg) three times a day scheduled.

Review of the residents narcotic count sheets revealed he had 2 cards of Tramadol 50 mg, 30 tablets in each card delivered on 7-30-21. He also received another card on 8-17-21 with 30 tablets.

Review of the residents August 2021 medication administration record (MAR) revealed the resident had an order for Acetaminophen 325 mg 2 tablets as needed every 4 hours for pain. According to the MAR there were no staff initials to indicate that the staff had offered the resident his as needed Acetaminophen.

The August 2021 MAR also included an as needed order for Tramadol 50 mg every 8 hours. The MAR revealed staff gave the medication to the resident on the 7th, 8th, and twice on the 10th. The narcotic count sheet revealed the resident refused to take the medication one of the

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S3200	Continued From page 7 times on the 10th. The August 2021 MAR also revealed that the Tramadol 50 mg scheduled to be administered by staff three times a day was not initiated in the resident's MAR until 8-11-21 at 11:24 PM, 2 days after receiving the written physicians order. On 8-24-21 at 4:15 PM operator/licensed nurse communicated via email that technically speaking the order for the scheduled Tramadol should have been in the electronic system the day the order was received, 8-9-21. The operator/licensed nurse failed to ensure that resident #100's pain medication was administered by facility staff according to the medical providers written orders and acceptable standards of practice.	S3200		
S3305 SS=E	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service;	S3305		

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S3305	Continued From page 8 (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; and (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-42-207(a)(b)(4) The facility reported a census of 35 residents. The sample included 3 residents. Based on observation and interview the operator failed to ensure the provision of a safe, sanitary and comfortable environment by the failure to properly clean 1 (#100) of 3 resident's bathroom. The operator also failed to ensure sanitary conditions by the failure to ensure staff sanitized silverware and drinking cups washed in the Cottages. Findings included: - Review of resident #100's medical record revealed the resident moved into the facility on 7-19-21 with a diagnosis of degenerative dementia and aortic stenosis.	S3305		

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S3305	Continued From page 9	S3305		

Review of the resident's functional capacity screens dated 7-19-21 and 8-1-21 revealed the resident was totally incontinent and also identified the resident had inappropriate behaviors.

Review of the residents negotiated service agreement/health care service plan dated 7-19-21 and 8-1-21 revealed revealed staff needed to provide standard housekeeping services 2 times per week which included deep cleaning of the restroom. Smaller cleaning jobs will be done throughout the week as needed.

Observation of resident #100's room on 8-18-21 at 1:20 PM revealed the following:
1. On the floor in the closet was a pile of clothing and sheets that were dirty. The clothing and a blanket had areas of chocolate pudding on them and there was a sheet with an incontinent pad that was wet.
2. In the bathroom on the grab bar beside the toilet was dried brown, gritty material that appeared to be feces.

On 8-18-21 at 1:22 PM licensed nurse C looked at the area on the grab bar and stated "it is either feces or chocolate pudding".

On 8-18-21 at 1:40 PM certified nursing assistant B reported that she had given the resident chocolate pudding this morning after staff got him cleaned up and dressed for the day and he threw the chocolate pudding across the room. Staff B stated she cleaned it up the best she could. Staff B also stated that staff come in and clean the residents room regularly and think they come in and clean his bathroom every day. When surveyor asked what the dried on material was on the grab bar certified nursing assistant B just shrugged her shoulders.

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S3305	Continued From page 10 On 8-18-21 at 4:40 PM certified medication aide D looked at the grab bar in the resident's room and stated the fried on material "looked like feces". On 8-24-21 at 8:58 AM housekeeping staff I reported resident #100's room was scheduled to be cleaned every Friday and his room was one that staff cleaned more often. On 8-24-21 at 11:17 AM housekeeping staff J reported the operator had her spot check the resident's room every day to see if there was anything that needed cleaned. It was deep cleaned on Fridays. The operator failed to ensure the resident's bathroom was kept clean in order to provide a safe, sanitary and comfortable environment for the resident. - Observation on 8-18-21 at 1:08 PM revealed the Cottages kitchen area had a 2 compartment sink on one counter and another sink on the side counter with an empty dish rack beside it. The 2 compartment sink contained dirty silverware. At 1:08 AM certified nursing staff B reported staff rinsed off all the dished and sent the plates and some of the glasses back to the main kitchen to be washed but the silverware and the cups are washed in this kitchen. Staff B stated there was sanitizer in the cabinet (pointed to a locked cabinet) that we are supposed to use when washing dishes. Staff B had to get keys from housekeeping staff because there were no keys to the cabinet on the Cottages. When staff B opened the cabinet contained 1 bottle of	S3305		

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S3305	Continued From page 11 disinfectant - not sanitizer for dishes. Staff B stated that was not what staff were supposed to use and there also used to be a red bucket in the cabinet we used for rinsing. Staff B stated the Cottage staff had just been washing with a liquid dish soap and rinsing with water and not sanitizing the dishes. 8-18-21 at 4:00 PM dietary staff A confirmed if staff kept any silverware or dishes on the Cottages they needed to be sanitizing them after rinsing them off. Review of the washing and sanitizing dishes policy dated 3-18-2014 revealed all dishes and utensils will be washed and sanitized according to accepted procedures for washing machines and hand washing. Under the hand washing instrutions it included to sanitize for one minute to kill any remaining bacteria in an appropriate sanitizing solution. The operator failed to ensure staff provided sanitary conditions for food service by the failure to ensure staff sanitized dishes according to standards of practice.	S3305		