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	N081006	A. BUILDING: _____ B. WING _____	C 07/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF MANHATTAN	1923 LITTLE KITTEN AVE MANHATTAN, KS 66502

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S 000	INITIAL COMMENTS The following citations represent the findings of a Licensure Resurvey at the above named Assisted Living Facility on 7/14/2021, 7/15/2021, 7/19/2021, and 7/20/2021. Complaints #163162; #162995; #160912: #150277; and #146120 also investigated.	S 000		
S 140 SS=F	26-39-103 (i) Resident Right Privacy and Confidentiality (i) Privacy and confidentiality. The administrator or operator shall ensure that each resident is afforded the right to personal privacy and confidentiality of personal and clinical records. (1) The administrator or operator shall ensure that each resident is provided privacy during medical and nursing treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. (2) The administrator or operator shall ensure that the personal and clinical records of the resident are maintained in a confidential manner. (3) The administrator or operator shall ensure that a release signed by the resident or the resident's legal representative is obtained before records are released to anyone outside the adult care home, except in the case of transfer to another health care institution or as required by law. This STANDARD is not met as evidenced by: KAR 26-39-103(i)(1) The census equalled 19 the sample included three Residents. Based on observations, interviews, and review of records, for three of	S 140		

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

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S 140	Continued From page 1 three sampled (#189, #187, and #185), and for all non-sampled Residents, the Operator failed to ensure privacy and confidentiality of all Residents who participated in personal visits, personal meetings, and meetings of family and Resident groups in the common areas of the facility under video and audio surveillance. Findings included: - On 7/14/2021 at 11:40am while completing the entrance conference, Operator #G confirmed all common areas of facility equipped with video and audio surveillance equipment. The common areas confirmed to include hallways, dining room, activity areas, sitting areas, TV/game room, and entry/exits. Operator #G stated the surveillance equipment in place when he started position in February 2021... stated the use of surveillance equipment is "part of the conversation" at time of admission. Observations during tour of facility confirmed the placement of cameras in the hallways and common sitting/gathering areas of the facility. On 7/14/2021 at 2:47pm Operator #G stated the company IT department reported video and audio recordings available from time of recording for two weeks... Operator #G stated I'm not aware of any written notice or posted notice provided to inform Residents, family members, and visitors these areas monitored. Operator #G confirmed persons in these areas could carry on a conversation unaware it was not private. By review of records for sampled Residents #189, #187, and #185, no written notice or other information included in the admission process paperwork, identifying the use of video and audio	S 140		

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S 140	Continued From page 2 surveillance equipment. By observations on 7/14/2021 at 10:30am through 7/15/2021 at 6:30pm, no posted notices of video and audio surveillance equipment in use. For all Residents of facility, the Operator failed to ensure each Resident provided privacy during visits and meetings with each other, with family members, with visitors, and in Resident groups.	S 140		
S3225 SS=E	26-41-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the facility and each time the resident experiences any significant change in condition. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l) The census equalled 19 the sampled included three Residents. The facility Roster identified 13 Residents with facility managed medications and treatments. Based on interview and review of records, for two of three sampled Residents with	S3225		

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S3225	Continued From page 3 facility managed medications (#185 and #187), and for one sampled Resident who self administered medications (#189), the Operator failed to ensure a licensed pharmacist conducted a medication regimen review at least quarterly. Findings included: - Review of record revealed #185 admitted to facility 8/20/18 with diagnoses of dementia, anxiety, gastroesophageal reflux disease, insomnia, and hypothyroidism. The current functional capacity screen dated 01/26/21 assessed #185 in need of physical assistance (2) with medication and treatment management. The current negotiated service agreement documented the facility to manage and administer medications and treatments. The medical record included MAR's (medication administration records) to document this service. Record review revealed the medical record lacked quarterly medication regime reviews by a licensed pharmacist prior to March 2021. The record included medication regime reviews for March 2021 and June 2021. On 7/19/21 at 2:26pm RCC (Resident Care Coordinator) #H stated the facility utilizes multiple pharmacist consultants... #185 was inadvertently not added to the list for them to review quarterly until March 2021. For #185 the Operator failed to ensure a licensed pharmacist conducted a medication regimen review at least quarterly.	S3225		

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S3225	Continued From page 4 - Review of record revealed #187 admitted to facility 3/13/19 with diagnoses of polyosteoarthritis, hypertension, gastroesophageal reflux disease, major depressive disorder, squamous cancer of the skin, diabetes, and ataxia. The current functional capacity screen dated 02/03/21 assessed #187 independent (0) for ability to manage medications and treatments. The current negotiated service agreement documented #187 to self administer some or all medications. Record review revealed #187 had not declined routine medication regime reviews, but the medical record lacked quarterly medication regime reviews by a licensed pharmacist prior to March 2021. The record included medication regime reviews for March 2021 and June 2021. On 7/19/21 at 2:26pm RCC (Resident Care Coordinator) #H stated the facility utilizes multiple pharmacist consultants... #187 was inadvertently not added to the list for them to review quarterly until March 2021. For #187 the Operator failed to ensure a licensed pharmacist conducted a medication regimen review at least quarterly. - Review of record revealed #189 admitted to facility 5/07/18 with diagnoses of Parkinson's, angina pectoris, dementia, hypertension, chronic obstructive pulmonary disease, gasstroesophageal reflux disease, and fibromyalgia. The current functional capacity screen dated	S3225		

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S3225	Continued From page 5 02/16/21 assessed #189 in need of physical assistance (2) with medication and treatment management. The current negotiated service agreement documented the facility to manage and administer medications and treatments. The medical record included MAR's (medication administration records) to document this service. Record review revealed the medical record lacked quarterly medication regime reviews by a licensed pharmacist from 08/2019 to 02/2020. The record included quarterly medication regime reviews for the remaining periods since admission. On 7/15/21 at 3:50pm RCC (Resident Care Coordinator) #H confirmed medication reviews missing for the period from August 2019 to February 2020... not sure of the reason for that... medical record system has changed recently and there may be information in the old system to explain the gap. For #189 the Operator failed to ensure a licensed pharmacist conducted a medication regimen review at least quarterly.	S3225		
S3227 SS=E	26-41-205 (l) (2) Medication Regimen Review Variance Report (l) (2) The licensed pharmacist or licensed nurse shall notify the medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist shall notify a licensed nurse within 48 hours of any variance identified in the resident ' s regimen review that does not	S3227		

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S3227	Continued From page 6 require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident ' s medical care provider. The licensed nurse shall seek a response from the medical care provider within five working days of the medical care provider ' s notification of a variance. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l)(2) The census equalled 19 the sampled included three Residents. The facility Roster identified 13 Residents with facility managed medications and treatments. Based on interview and review of records, for two of three sampled Residents with facility managed medications (#185 and #187), and for one sampled Resident who self administered medications (#189), the Operator failed to ensure a licensed nurse sought a response from the medical care provider within five working days of notification of a pharmacist identified variance. Findings included: - Review of record revealed #185 admitted to facility 8/20/18 with diagnoses of dementia, anxiety, gastroesophageal reflux disease, insomnia, and hypothyroidism. The current functional capacity screen dated 01/26/21 assessed #185 in need of physical assistance (2) with medication and treatment management. The current negotiated service agreement	S3227		

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S3227	Continued From page 7 documented the facility to manage and administer medications and treatments. The medical record included MAR's (medication administration records) to document this service. Record review revealed a 6/01/21 pharmacist recommendation to evaluate and decrease the dose of melatonin (supplement to aid sleep). The record lacked evidence this recommendation submitted to the physician and a response obtained. On 7/15/21 at 4:56pm RCC (Resident Care Coordinator) #H confirmed the pharmacist recommendation of 6/01/21 had not been submitted to the physician for a response. For #185 the Operator failed to ensure a licensed nurse sought a response from the medical care provider within five working days of notification of a pharmacist identified variance. - Review of record revealed #187 admitted to facility 3/13/19 with diagnoses of polyosteoarthritis, hypertension, gastroesophageal reflux disease, major depressive disorder, squamous cancer of the skin, diabetes, and ataxia. The current functional capacity screen dated 02/03/21 assessed #187 independent (0) for ability to manage medications and treatments. The current negotiated service agreement documented #187 to self administer some or all medications. #187 had not declined routine medication regime reviews. Record review revealed a 3/05/21 pharmacist	S3227		

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S3227	Continued From page 8 recommendation to change an oral diabetic medication (glimapiride). The record lacked a response to this recommendation. On 7/15/21 at 3:50pm RCC (Resident Care Coordinator) #H stated the recommendation was still in the folder of consultant recommendations on RCC's desk... confirmed the recommendation had not been acted upon or sent to the physician for response. For #187 the Operator failed to ensure a licensed nurse sought a response from the medical care provider within five working days of notification of a pharmacist identified variance. - Review of record revealed #189 admitted to facility 5/07/18 with diagnoses of Parkinson's, angina pectoris, dementia, hypertension, chronic obstructive pulmonary disease, gastroesophageal reflux disease, and fibromyalgia. The current functional capacity screen dated 02/16/21 assessed #189 in need of physical assistance (2) with medication and treatment management. The current negotiated service agreement documented the facility to manage and administer medications and treatments. The medical record included MAR's (medication administration records) to document this service. Record review revealed an 11/03/20 pharmacist recommendation to change an order for singulair (asthma medication). The record lacked a physician's response to this recommendation. The record included a 02/08/21 pharmacist recommendation to change an order for lexapro (anti-depressant). The record lacked a	S3227		

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S3227	Continued From page 9 physician's response to this recommendation. On 7/15/21 at 3:50pm RCC (Resident Care Coordinator) #H stated the recommendation had been sent to a mental health center, and although they sent a new medication order to the pharmacy, never returned the form to the facility... for the singulair no submission to physician with response located. For #189 the Operator failed to ensure a licensed nurse sought a response from the medical care provider within five working days of notification of a pharmacist identified variance.	S3227		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (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 facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' 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	S3280		

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S3280	Continued From page 10 by: KAR 26-41-104(d) The census equalled 19, the sample included three Residents. The facility identified 18 employees hired since the last Resurvey. Based on interview and review of record for all Residents and all employees of facility, the Operator failed to ensure disaster and emergency preparedness by completing a quarterly review of the facility's emergency management plan with Residents. Findings included: - On 7/14/21 Surveyor requested documentation of the facility's quarterly emergency management plan reviews for Residents and employees. On 7/14/2021 during the entrance conference Operator #G stated I have the employee disaster reviews in the inservice book and Activity Director #I has the Resident disaster reviews. On 7/14/2021 at 1:08pm reviewed Resident disaster reviews with Activity Director #I. The dates of disaster reviews completed since the last Resurvey included: 12/17/2019 01/01/2020 04/02/2020 07/02/2020 04/01/2021 7/01/2021 Activity Director #I stated my normal process is to review a condensed version of the disaster plan with them in the dining room prior to lunch... and if someone not present in the dining room I go to	S3280		

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S3280	Continued From page 11 individual rooms and review it with them one on one... I have no idea why there are no reviews between July of last year and April of this year... looked through entire book... they are not here... the previous Operator (no longer here) did these for awhile then I took back over perhaps in February 2021. On 7/15/2021 reviewed employee disaster reviews with Operator #G. Quarterly reviews recorded for employees on the following dates: 7/15/2021 4/15/2021 01/13/2021 10/21/2020 7/15/2020 4/23/2020 Operator #G confirmed he did not have Resident quarterly disaster reviews between July of 2020 and April of 2021. The Operator failed to ensure disaster and emergency preparedness by completing quarterly emergency plan reviews with Residents.	S3280		