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	N008011	A. BUILDING: _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey and complaints #163157, 163025, 162869, 162872, 162666, 161044, 160906, 160760, 160058, and 159661 for the above named facility conducted on 06-03-21, 06-08-21, 06-09-21, 06-10-21, 06-14-21, 06-15-21, 06-16-21, 06-17-21, 06-23-21 and 06-24-21.	S 000		
S3028 SS=F	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S3028		

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

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f)(3)(A)(B)(C)(E) The facility reported a census of 68 residents. Administrator D reported an allegation of exploitation regarding missing controlled substances for resident #289 and resident #800's allegation of neglect by 3 direct care staff (certified medication aide B and certified nurse aides A and C) to provide care and services. Based on record review and interview the administrator failed to immediately protect residents from further potential neglect during an investigation and failed to begin an investigation including statements from the alleged perpetrators, statements from other residents, review of the call light log and video surveillance. The failure to suspended named alleged perpetrators during the investigation had the potential to affect all residents. The administrator also failed to thoroughly investigate resident #289's missing controlled substances, failed to submit a report to the State agency of the investigation with the results of the investigation and any actions taken. Findings included: - Record review for resident #800 revealed an admission date of 12-23-2019 with diagnoses of chronic respiratory failure with hypoxia, fluid overload, lymphedema, hypertension, chronic obstructive pulmonary disease, muscle weakness, diabetes mellitus, bipolar and personality disorder.	S3028		

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S3028	Continued From page 2 The annual functional capacity screen dated 03-01-21 identified the resident with intact cognition and needed physical assistance with bathing, dressing, toileting, transfers, walking/mobility and frequently incontinent of bladder. She was not marked as having impaired decision making or socially inappropriate behaviors. The negotiated service agreement dated 03-01-21 included services for physical assistance by staff with bathing and dressing; staff to assist with toileting and with incontinent care. The resident used a cane independently and a wheelchair for long distance with physical assistance marked. Under the section for Health Care Services the category for behavioral management was not marked The Resident Health Service Plan dated 03-01-21 directed staff to assist the resident with dressing as needed and staff to assist with incontinent issues. The HSP does not include any specific details for when or how much assistance the resident needs with toileting/incontinent care. The resident can walk short distance with a cane and a wheelchair for long distances. On 06-07-21 at 9:29 AM administrator D made a report to the State agency about resident #800's allegation of neglect for 3 named direct care staff (certified medication aide {CMA} B and certified nurse aides {CNA} A and C). The resident alleged CMA B and CNA A and C refused to help her out of the dining room as she was urine soaked over the memorial weekend (05-28-21 thru 06-01-21). On 06-08-21 at 4:15 PM resident #800 reported she was seated in her wheelchair which she could not self-propel at times related to the seat	S3028		

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S3028	Continued From page 3	S3028		

breakdown and her arm strength. She said she was seated at the dining room table doing some writing. She said staff had brought her several glasses of beverages and some snack items. A little later she had the urge to urinate, she turned on her call alert pendant and no one came. She could not hold her urine any longer and was incontinent onto the floor. CMA B came about 45 minutes after she had activated the call alert pendant and CMA B said she was not a certified nurse aide but would get her someone to help. Resident #800 said no one came for about 30 minutes after that.

On 06-08-21 at 5:39 AM a call to the facility revealed the staff on duty included CNA A and CMA B but they could not come to the phone due to providing cares.

Interview on 06-09-21 at 1:40 PM administrator D reported she had no documentation for the investigation. She confirmed she did not suspend the 3 named staff to protect residents during the investigation, she had not spoken with any other residents, had no statements from staff, had not reviewed the call light log or the video surveillance. She said she had spoken with the 3 named direct care staff but had no notes about the conversations and could not totally remember what they said.

On 06-09-21 administrator D upon request provided a policy for abuse, neglect and exploitation with a revision date of 01-23-2007 (under the former name for the facility). The policy directed for all incidents of reported as suspected abuse, neglect or exploitation shall be investigated. Under the section for protection the policy directed upon receiving a report of abuse, neglect or exploitation ... if a staff member has

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S3028	Continued From page 4 been identified as the alleged perpetrator, that individual will be suspended from employment until the investigation has been completed. The administrator failed to immediately protect residents from further potential neglect during an investigation and failed to begin an investigation including statements from the alleged perpetrators, statements from other residents, review of the call light log and video surveillance. The failure to suspended named alleged perpetrators during the investigation had the potential to affect all residents. - On 06-03-21 licensed nurse E provided the resident roster which indicated the facility managed the medications for resident #289. On 05-24-21 at 3:25 PM administrator D reported to the State agency an allegation of exploitation related to a missing card of controlled medication for resident #289. The report indicated the administrator reported the lost controlled substance to the local police department, reviewed the narcotic (controlled substance) card count and drug tested all the certified medication aides (CMA) who work the cart with the missing controlled substance. The administrator was provided a complaint #162666 and directed to submit the report of the investigation. On 06-15-21 the State agency confirmed the facility had not submitted a report for complaint #162666. Multiple request on 06-15-21 and 06-16-21 to review the investigation completed by the facility for complaint #16266 resulted in an email on 06-16-21 at 1:26 PM which included 8 pages.	S3028		

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S3028	Continued From page 5 One a copy of the local law enforcement card with a case # and 4 pages of controlled substance sheets for resident #289 and 3 pages titled narcotic card count which included multiple residents. The email lacked any report summary of the investigation, statements from staff, results of the investigation or actions taken. On 06-17-21 during a phone conference administrator D confirmed that was all she had for the investigation. She confirmed no employee statements were obtained, she did not write up a summary of her investigation with actions taken and failed to submit a report to the State agency as required. The administrator failed to thoroughly investigate resident #289's missing controlled substances, failed to submit a report to the State agency of the investigation with the results of the investigation and any actions taken.	S3028		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility 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;	S3085		

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S3085	Continued From page 6 and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a)(1)(2) The facility reported a census of 68 residents. The sample included 6 residents. Based on interview and record review the administrator failed to ensure the written negotiated service agreement for 2 of 6 residents (#800 and #916) included a description of the services the resident would receive with identification of the provider for each service regarding a change in laundry services for resident #800 and start/stopping of wound care services for resident #916. Findings included: - Record review for resident #800 revealed an admission date of 12-23-2019 with diagnoses of chronic respiratory failure with hypoxia, fluid overload, lymphedema, hypertension, chronic obstructive pulmonary disease, muscle weakness, diabetes mellitus, bipolar and personality disorder. The annual functional capacity screen dated 03-01-21 identified the resident with intact cognition and needed physical assistance with bathing, dressing, toileting, transfers, walking/mobility and frequently incontinent of bladder. The negotiated service agreement (NSA) dated 03-01-21 included services for physical	S3085		

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assistance by staff with bathing and dressing; staff to assist with toileting (no specific details) and frequently incontinent care with no specific services indicated. Under housekeeping/laundry the NSA included weekly apartment cleaning, weekly personal laundry and weekly linens laundry with daily room tidy and trash pick-up added.

The Resident Health Service Plan dated 03-01-21 directed staff to assist the resident with dressing as needed and staff to assist with incontinent issues. The HSP does not include any specific details for when or how much assistance the resident needs with toileting/incontinent care. The resident can walk short distance with a cane and a wheelchair for long distances.

Review of the interdisciplinary progress notes revealed a long history of urine incontinence, needing assistance but saying she doesn't, urine on the floor, staining carpet and severe urine odors in the room.

Observation on 06-08-21 at 4:15 PM revealed the resident in her room with the door to the outside courtyard partially open. The room had a strong urine smell. The resident reported she could take herself to the bathroom in her apartment and manage her own incontinence. Later in an interview on 06-15-21 with the resident she indicated she was being charged for daily room cleaning, laundry and bed linen changes due to the bladder incontinence.

Interview with licensed nurse E on 06-16-21 confirmed the resident needed physical assistance to toilet and that the NSA did not reflect enough details for the service. She confirmed the resident received daily laundry as a

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S3085	Continued From page 8	S3085		

result of the incontinence and that the NSA was not amended to reflect the change in services.

The facility's policy for negotiated service agreement (undated) included: a written negotiated service agreement based on service needs or preference of the resident which shall include a description of the services to be provided and the provider of the service or services. ... the NSA shall be reviewed at least annually, revised if necessary ...

The administrator failed to ensure the written negotiated service agreement for resident #800 included a description of the services the resident would receive regarding details for toileting and incontinence as well as a change in laundry services.

- Record review for resident #916 revealed an admission date of 07-01-2015.

The annual functional capacity screen dated 10-12-2020 and 03-22-21 revealed the resident had intact cognition and required physical assistance with bathing, dressing, toileting, transfers, medication and treatment management.

The negotiated service agreement dated 10-12-2020 and 03-22-21 included a the name of a home health agency to provide outside services but failed to include a description of the services to be provided. Neither NSA had a revision or amendment to reflect starting services for wound care and stopping services for wound care.

Review of the interdisciplinary progress notes revealed the resident began wound care services

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S3085	Continued From page 9 from an outside agency on 02-12-21 and stopped these services on 04-16-21. Interview on 06-16-21 with licensed nurse E confirmed the resident received the services and the NSA was not amended to reflect the resident starting the service and stopping the service. The administrator failed to ensure the written negotiated service agreement for resident #916 included a description of the services the resident would receive regarding starting and stopping wound care services.	S3085		
S3171 SS=F	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: K.A.R. 26-41-204 (i) The facility reported a census of 68 residents. The sample included 6 residents. Based on interview and record review the administrator failed to ensure health care services were provided by qualified staff in accordance with acceptable standards of practice regarding call light response times when residents called for assistance and staff failed to respond timely with some being greater than an hour. This deficient practice had the potential to affect all residents. Findings included:	S3171		

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S3171	Continued From page 10 - During confidential interviews with residents on 06-03-21, 06-08-21 and 06-09-21 regarding care and services by the facility 5 residents reported they had to wait a long time to have their calls for assistance answered. On 06-09-21 administrator D reported the residents are issued a call pendent to wear around their neck or their wrist. The resident will push the button on the pendant to activate the alert to staff which goes to the pagers the staff carry. Staff reset the call pendant when they go to the resident. A request on 06-09-21 to review the call system log over the weekend beginning 05-28-21 (12:01 AM) through 06-01-21 (11:59 PM) revealed 38 residents activated their call alert pendant at least 1 time for assistance from staff. The record showed staff response time as follows: 33 of the 38 residents' calls took greater than 5 minutes for staff to respond 24 of the 38 residents' calls took greater than 10 minutes for staff to respond 21 of the 38 residents' calls took greater than 15 minutes for staff to respond 14 of the 38 residents' calls took greater than 30 minutes for staff to respond 8 of the 38 residents calls took greater than 45 minutes for staff to respond 6 of the 38 residents calls took greater than an hour for staff to respond The alarm report (for the call alerts) included a response time breakdown and color coded those times as follows: call alerts answered in 3 minutes or less were excellent (green color to the time), call alerts answered between 3 and 5 minutes were acceptable (light red color to the	S3171		

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S3171	Continued From page 11 time) and anything greater the 5 minutes was marked as needs improvement (dark red color to the time). An email request on 06-16-21 at 8:05 AM sent to administrator D and licensed nurse E to review the facility's policy and procedure regarding the call alert system and staff response time resulted in none provided. An online search for "Call light response time standard" provided the search result - in an article at www.myamericannurse.com which documented the following: "Of course, there are going to be emergency situations where the time it takes to answer a patient's call is going to be longer than the nurse or patient would like. However, on average, the patient should not have to wait longer than 3 to 4 minutes at the most to get their call light answered." The administrator failed to ensure health care services were provided by qualified staff in accordance with acceptable standards of practice regarding call light response times when residents called for assistance and staff failed to respond timely with some being greater than an hour. This deficient practice had the potential to affect all residents.	S3171		
S3186 SS=E	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the	S3186		

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S3186	Continued From page 12 administration and management of selected medications. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (b) The facility reported a census of 68 resident. The sample included 6 residents. Based on record review and interview the administrator failed to ensure the negotiated service agreement reflected self-administration of some medications and failed to identify who was responsible for the administration and management of selected medications for 2 of 6 residents sampled for medication management review (#800 and #916). Findings included: - Record review for resident #800 revealed an admission date of 12-23-2019 with diagnoses of chronic respiratory failure with hypoxia, fluid overload, lymphedema, hypertension, chronic obstructive pulmonary disease, muscle weakness, diabetes mellitus, bipolar and personality disorder. The annual functional capacity screen dated 03-01-21 identified the resident with intact cognition and needed physical assistance with medications and treatments. The self-administration of medication assessment dated 05-04-21 identified the resident had the ability to name her medications but not the	S3186		

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reason for them, can name side-effects of medications, remember to take timely and identify the correct dosage, read the label and identify the medications. She could open the containers and swallow safely. Under the comments section licensed nurse E wrote licensed/certified staff to administer medications and perform simple treatments.

The negotiated service agreement (NSA) dated 03-01-21 included services for medication management. Licensed nurse G marked the NSA with (resident) self-medication and by certified/licensed staff but failed to specify which medications the resident would self-administer and which the staff would administer. The NSA included certified staff to do simple treatments per order. The NSA further said to see the medication list attached and none was attached.

The Resident Health Service Plan (HSP) signed by licensed nurse G and dated 03-01-21 had the following boxes marked: self-administered, staff administered, injections and accuchecks (blood sugar testing). The additional directions included resident self-injects insulin after the certified medication aide dials the dose. Licensed/certified staff to administer medications and perform simple treatments. The HSP failed to specify which medications the resident would self-administer and which the staff would administer.

Review of the June 2021 medication administration record (MAR) revealed the following medications which staff recorded as being self-administered by the resident (U-SA): Advair HFA aerosol 2 puffs inhaled orally two times a day unsupervised self-administration Dorzolamide HCl solution 2% instill 1 drop in left

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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
S3186	Continued From page 14	S3186		

eye two times a day unsupervised self-administration
Durazol Emulsion 0.05% instill 1 drop in left eye four times a day unsupervised self-administration

Interview on 06-17-21 at 9:35 AM licensed nurse E confirmed the resident chose to self-administer selected medications and the facility administered the rest. She confirmed the NSA and the HSP lacked information regarding which medications the resident would self-administer and which the facility staff would administer.

The administrator failed to ensure the negotiated service agreement reflected self-administration of some medications and failed to identify who was responsible for the administration and management of selected medications for this resident.

- Record review for resident #916 revealed an admission date of 07-01-2015 with diagnoses of diabetes mellitus type 2, chronic obstructive pulmonary disease, hypertension, heart failure, edema, restless leg syndrome, major depressive disorder, anxiety disorder and pain.

The annual functional capacity screen dated 03-22-21 identified the resident with intact cognition and needed physical assistance with management of medications and treatments.

The self-administration assessment dated 05-04-21 by licensed nurse E identified the resident as capable to name her medications, give the reason for her medication, read the label, identify the medication and remember to take the medication at the correct time. Medications approved were listed as OTC (over the counter),

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vitamins, powders, creams and to see the list of OTCs in the chart. Under the comments licensed nurse E wrote certified staff to administer medications and preform simple treatments due to history of non-compliance.

In the negotiated service agreement (NSA) dated 03-23-21 licensed nurse E marked the boxes for medication management, self-administer and staff administer (see medication list attached but no list was attached). The NSA failed to identify which medications the resident would self-administer, and which medications staff would administer.

In the health service plan dated 03-22-21 licensed nurse E marked the boxes under medication self-administer, staff administered, injections and accuchecks (blood sugar testing). Under special instructions: licensed and certified staff to administer medications and perform simple treatments.

Review of the June 2021 medication administration record revealed the following medications which staff recorded as being self-administered by the resident (U-SA):
Advair Disks Aerosol Powder - inhale 1 puff two times a day, unsupervised self-administration
Flonase Suspension 1 spray alternating nostrils two times a day, unsupervised self-administration
Vitamin A & D ointment apply topically to abdominal wound edges for moisture/rash two times a day, unsupervised self-administration

Interview on 06-17-21 at 9:35 AM licensed nurse E confirmed the resident chose to self-administer selected medications and the facility administered the rest. She confirmed the NSA and the HSP lacked information regarding which medications

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S3186	Continued From page 16 the resident would self-administer and which the facility staff would administer. The administrator failed to ensure the negotiated service agreement reflected self-administration of some medications and failed to identify who was responsible for the administration and management of selected medications for this resident.	S3186		
S3202 SS=E	26-41-205 (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. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) (4) The facility reported a census of 68 residents. The facility identified they managed the insulin for 12 residents. Licensed nurse E identified 12 currently employed certified medication aides (CMAs) who had the responsibility to perform blood sugar testing for residents, prepare and dial the dose of insulin by injector pen which the resident injected. Based on interview and record review the administrator failed to ensure a licensed nurse oriented and instructed certified medication aides (CMAs) in the performance of blood sugar testing, dialing the prescribed dose of insulin by injector pen(s) for the resident to inject and further failed to document a demonstration of the staff's competency signed by the nurse and	S3202		

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S3202	Continued From page 17 the CMA in each employee's personnel record (4 CMAs had blood sugar testing which were not signed by the CMA and none of the 12 had documentation regarding insulin pen administration). Findings included: - During the entrance conference on 06/03/21 at 1:16 PM with administrator D and licensed nurse E reported CMAs were delegated to perform blood sugar testing for residents, preparing and dialing the prescribed insulin on the pen for the resident to inject. A request on 06/08/21 to review documentation of a licensed nurse instructing CMAs and with competency evaluations resulted in licensed nurse E providing 4 single sheets titled, CMA Med Pass Proficiency for CMA B, H, J and K. The sheets included Glucometer testing (blood sugar testing) with a X in the column identified as "S". The sheet had the name of the CMA, the nurse's signature and the date but was not signed by the CMA. None of the 12 CMAs identified as current employees had documentation for orientation/instruction and competency with insulin pens. Interview on 06/08/21 licensed nurse E confirmed all the CMAs employed by the facility were expected to perform blood sugar testing and dial the dose of insulin for residents which the facility managed medications/treatments. She confirmed she only had the 4 CMAs with documented sign off to perform blood sugar testing and none were documented as signed off with training and competency to allow them to prepare and dial dosage of insulin pens.	S3202		

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S3202	Continued From page 18 The administrator failed to ensure a licensed nurse oriented and instructed all CMAs in the performance of blood sugar testing, preparing and dialing the prescribed dose of insulin by injector pen(s) and further failed to document a demonstration of the staff's competency signed by the nurse and the CMA in each employee's personnel record.	S3202		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g) (3) The facility reported a census of 68 residents and the facility managed medications for 65 of those residents. Based on observation and interview the administrator failed to ensure a licensed nurse or licensed pharmacist labeled over-the-counter medications with the resident's full name for 9 residents whose medications the	S3211		

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S3211	Continued From page 19 facility managed (#334, #440, #442, #447, #451, #509, #513, #516 and #610). Findings included: - On 06-03-21 licensed nurse E provided the resident roster which indicated the facility managed medications/treatments for 65 residents. On 06-03-21 at 10:15 AM certified medication aide (CMA) L opened the medication cart for the C hall. Observation revealed resident #334 had 4 bottles of over-the-counter (OTC) medications labeled with only the resident's first name. On 06-03-21 at 10:54 AM CMA M opened the medication cart for the A hall. Observation revealed OTC medications which were not labeled with their full name and had only their first name for the following residents: Resident #440 had 6 bottles or packages of OTC medications Resident #442 had 2 bottles of OTC medications Resident #447 had 1 bottle of OTC medications Resident #610 had 1 bottle of OTC medications On 06-03-21 at 11:09 AM CMA O opened the medication cart for the B hall. Observation revealed resident #451 had a bottle of Mylanta labeled with only the resident's first name. On 06-03-21 at 11:16 AM CMA N opened the medication cart for the D hall. Observation revealed OTC medications labeled with only the resident's first name or no name for the following residents: Resident #509 had a bottle of multivitamins, resident #516 had a bottle of Senna-S, resident #513 had a bottle of vitamin D-3 and a bottle of	S3211		

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S3211	Continued From page 20 dry eyes with no name which could be separated from the box that had the resident's first name only. Confidential interviews with 2 of the 4 CMAs on 06-03-21 revealed she would write the resident's name and date opened on the bottle. The administrator operator failed to ensure a licensed nurse or licensed pharmacist labeled over-the-counter medications with the resident's full name for 9 residents (#334, #440, #442, #447, #451, #509, #513, #516 and #610).	S3211		
S3215 SS=E	26-41-205 (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 managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility 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.	S3215		

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S3215	Continued From page 21 (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 facility. (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 26-41-205 (h) (4) The facility reported a census of 68 residents. The facility identified 12 residents who required insulin injections managed by the facility. Based on observation, record review and interview the operator failed to ensure licensed nurses and certified medication aides could not administer medications beyond the manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated insulin pens once opened for 5 of 12 residents whose insulin the facility managed (#623, #649, #711, #722 and #916). Findings included: - On 06-03-21 licensed nurse E provided the resident roster which identified facility management for 12 residents who received facility managed insulin by multi-dose insulin pens which included residents #623, #649, #711, #722 and #916. On 06-03-21 at 10:15 AM revealed certified medication aide (CMA) L opened the medication	S3215		

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S3215	Continued From page 22	S3215		

cart for the C hall. In the top drawer were diabetic supplies and insulin pens managed by the facility. Observation revealed an open and used Humalog insulin pen for resident #623 and no date when it was opened. In the drawer was another Humalog pen with resident #916's name on it. The pen had an unreadable marking from a black marker which did not look like a date. CMA L said she had opened the pen, dated it and it must have rubbed off.

On 06-03-21 at 10:54 AM CMA M opened the medication cart for the A hall. Observation revealed in the top drawer were blood sugar testing supplies and insulin pens. An open and used Levemir pen with no resident name on it and CMA M identified as belonging to resident #649. The insulin pen had a white label with a place to write date opened and expiration date. The date of 06-01-21 was written on the expiration line. CMA M thought it was the date when it was opened. She checked the orders for the resident who received 20 units twice a day for a total of 40 units. There was approximately 29 units left in the syringe. The Levemir insulin pen starts with 250 units. If the insulin pen was opened on 06-01-21 there would be approximately 150 units left (40 units on 06-01-21, 40 units on 06-02-21 and 20 units the morning of 06-03-21 for total of 100 units).

Also, in the top drawer was a Levemir pen for resident #711. This pen also had the white label with a line for opened date and line for expiration date. On the expiration line was 06-01-21 but the pen did not appear to have been used and still registered 250 units.

On 06-03-21 at 11:16 AM CMA N opened the medication cart for the D hall. Observation

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S3215	Continued From page 23 revealed a Levemir pen for resident #722 it had a date of 05-25-21 written on it. However, the pen still had 250 units in it. CMA N reported she thought she was to date the pen when she took it out of the refrigerator. On 06-03-21 at about 11:30 AM licensed nurse E confirmed the CMAs dialed the dose of the insulin for the residents and were expected to date the insulin with the first use to ensure they pen was not used past the manufacture's date. An email request was made on 06-17-21 at 8:05 AM for the facility's policy and procedure for blood sugar testing and insulin administration resulted in none provided. Humalog Kwik pen manufacture recommended to store opened insulin at room temperature for up to 28 days and discard even if insulin remained. The Levemir FlexTouch manufacture recommended to store opened insulin at room temperature for up to 42 days and discard even if insulin remained. The operator failed to ensure licensed nurses and certified medication aides could not administer medications beyond the medication manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated insulin pens once opened.	S3215		
S3256 SS=E	26-41-105 (c) Resident Records Safeguards (c) Each administrator or operator shall ensure the safeguarding of resident records against the following:(1) Loss; (2) destruction;	S3256		

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S3256	Continued From page 24 (3) fire; (4) theft; and (5) unauthorized use. This REQUIREMENT is not met as evidenced by: KAR 26-41-105 (c)(4)(5) The facility reported a census of 68 residents. Based on observation, interview and record review the administrator failed to safeguard the records of current residents and discharged residents against possible theft or unauthorized use when these records were stored in unsealed cardboard file boxes in an unsecured room accessible to all staff, residents and possible visitors. Findings included: - On 06-03-21 at approximately administrator D took the surveyor to a conference room located off a common hallway and across from the activity room. The door to the conference room was open and not under visual supervision. Observation revealed 108 unsealed cardboard file type boxes which were labeled as containing resident records of 2017 state reportable investigations, discharged residents 2016 - 2019, shift to shift report sheets, bath sheets, care logs, missed or late medication logs, and some which were not identified. Observation on 06-03-21 revealed several staff who entered the conference room to access the	S3256		

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S3256	Continued From page 25 open faced file cabinet and or the portable phones on the charger bases. The activity room directly across the hall had residents and staff which came in and out of the area. Interview on 06-03-21 at 11:42 AM with licensed nurse E and licensed nurse F confirmed the file boxes contained confidential resident records which should be secured. Licensed nurse E reported the file boxes were stored like this before she began employment 02-04-21 and the door was routinely kept open for staff to access the phone chargers. An email request on 06-16-21 at 8:05 AM for the facility's policy and procedure for management of residents' confidential records resulted in none provided. The administrator failed to safeguard the records of discharged residents against possible theft or unauthorized use.	S3256		
S3310 SS=F	26-41-207 (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; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105	S3310		

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S3310	Continued From page 26 This REQUIREMENT is not met as evidenced by: K.A.R. 26-207(c) The facility reported a census of 68 residents. The sample included 6 residents. Based on interview and record review the administrator 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 when 5 of 5 personnel records reviewed (administrator D, licensed nurse E and direct care staff Q, R and S) lacked a TB questionnaire, 2 of 5 lacked evidence of TB testing, 5 of 6 residents sampled (#118, #139, #700, #800 and #916) lacked a TB questionnaire and 3 of 6 resident sampled (#139, #700, and #800) lacked evidence of TB testing. Findings included: - Record review of sampled residents revealed the following information related to TB questionnaire and testing at the time of admission and annually as required: Resident #139 admitted to the facility on 04-09-2020. The record lacked evidence of a TB questionnaire at the time of admission and no evidence of TB testing. Resident #700 admitted to the facility on 12-24-2019. The record lacked evidence of a TB questionnaire at the time of admission and no evidence of TB testing. Resident #800 admitted to the facility on 12-23-2019. The record lacked evidence of a TB questionnaire at the time of admission and no	S3310		

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evidence of TB testing.
Resident #118 admitted to the facility on 12-05-2016. The record lacked an annually TB questionnaire with the last one provided dated 06-05-2017.
Resident #916 admitted to the facility on 07-01-2015. The record lacked an annually TB questionnaire with the last one provided dated 08-17-2017.

Interview with medical records staff P on 06-09-21 at 1:06 PM confirmed the only TB records she could find for the above residents were the 2 questionnaires completed in 2017.

Interview with licensed nurse E on 06-09-21 confirmed she had no additional information for the above residents regarding TB questionnaires or testing.

Personnel record review done on 06-08-21 and 06-09-21 for administrator D, licensed nurse E, and direct care staff Q, R and S revealed none of the records had a TB questionnaire and 2 lacked evidence of TB testing as follows:
Direct care staff Q began employment on 07-14-2020. The record lacked any information related to TB questionnaire or testing.
Direct care staff R began employment on 08-04-2020. The record included a single sheet of paper titled TB testing documentation form which had the employee's name on it and date of hire but the rest of the form was blank. The record lacked a TB questionnaire.
Direct care staff S, administrator D and licensed nurse E's personnel record lacked a TB questionnaire.

On 06-09-21 administrator D confirmed all 5 personnel files reviewed lacked TB

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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
S3310	Continued From page 28 questionnaires and the 2 hired in 2020 lacked TB testing. An email request on 06-16-21 at 8:05 AM for the facility's policy and procedures regarding TB resulted in none provided. The administrator 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 when 5 of 5 personnel records reviewed (administrator D, licensed nurse E and direct care staff Q, R and S) lacked a TB questionnaire, 2 of 5 lacked evidence of TB testing, 5 of 6 residents sampled (#118, #139, #700, #800 and #916) lacked a TB questionnaire and 3 of 6 resident sampled (#139, #700, and #800) lacked evidence of TB testing.	S3310		
S3320 SS=F	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care 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. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26,	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	C 06/24/2021

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S3320	Continued From page 29 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254 (a) The facility reported a census of 68 residents. Based on observation, interview and record review the administrator failed to ensure the facility was equipped and maintained to protect the health and safety of residents, personnel and the public regarding unsecured oxygen cylinders and a helium cylinder. Findings included: - During the initial tour on 06-03-21 observation of the medication room at 11:26 AM revealed 2 unsecured partially filled oxygen tanks placed on the floor next to the wall that was adjacent to the dining room. The tanks sat on the floor without any securing device to prevent them from falling over, breaking the cylinder head creating the potential for the tank to become a projectile from a compressed air leak. On 06-03-21 at 11:30 AM licensed nurse E confirmed oxygen tanks should be secured in a holder. On 06-08-21 at 2:20 PM observation revealed an open door to the room used for activities. On the floor by the door sat a small cylinder of helium (used to air up balloons) which was not secured.	S3320		

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S3320	Continued From page 30 Interview on 06-08-21 with administrator D confirmed the cylinder should be secured to prevent accidental falling over and damage to the valve with the potential to become a projectile from the compressed air. A Google search resulted in a finding from the compressed gas association which directed never drop or allow tanks/cylinders to strike each other or against other surfaces violently (as in a tipped or falling situation). The administrator failed to ensure the facility was equipped and maintained to protect the health and safety of residents, personnel and the public regarding unsecured oxygen cylinders and a helium cylinder.	S3320		