STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING: _____ B. WING _____	C 06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD 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 an abbreviated survey for complaints # 163197, 163265, 162987, 162590 and 162463 of the above named facility conducted on 6/17/2021, 6/23/2021, 6/24/2021, 6/28/2021 and 6/29/2021.	S 000		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement 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; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (d) (2) The facility reported a census of 38 residents. The sample included 3 residents and 1 focused review. Based on record review and interview, the operator failed to ensure the negotiated service agreement for resident #1, was updated to reflect the resident changes in behaviors, unsteadiness on her feet, and the service for occupational/physical therapy as ordered after a fall with an injury.	S3092		

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

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S3092	Continued From page 1	S3092		

Findings included:

- Record review on 6/17/2021 for resident #1 revealed an admission date of 2/2/2021, with diagnoses of Addison disease, Cognitive disorder, insomnia, transient ischemia attack, rectal prolapse and a left bundle branch block.

Record review on 6/17/2021 of the functional capacity screen dated 2/21/2021 revealed the resident was independent with bathing and dressing, she required physical assistance with toileting. She lacked the ability to manager her own medications, and used no mobility device, she had impaired short-term memory, memory /recall and impaired decision making.

Record review on 6/17/2021 of the negotiated service agreement/health service plan dated 3/5/2021, identified the resident was independent with bathing, dressing, and capable of performing hygiene independently. The facility would assist resident in changing incontinent products and manage her medications. The resident was independent with all transfers and mobility (with or without supportive devices). Staff were to report changes to the health care coordinator. Unacceptable behavior is corrected with verbal reminders or cues, she experienced agitation and desire to "get back Home", staff to provide resident with reorientation and support. The record lacked documentation of an outside service provider.

Record review on 6/23/2021 of the resident notes reveal the following entries:

2/25/2021 at 3:02 p.m. .....Spoke with daughter

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S3092	Continued From page 2	S3092		

today about resident's behavior. Resident insist that a lady across the hall is moving into room. Resident said that lady comes over when I am gone and just piles up her things here in my living room. She also thinks that some of her clothes are in the closet across the hall. I asked her how she knew this, and she said she saw them. Spoke with resident and explained that we cannot just go into other residents' apartments. If she needs anything we ask that she comes to staff. Signature of writer unreadable.

3/1/2021 at 11:54 a.m. Resident's daughter spoke with resident's primary care provider about behaviors. The primary care provider called this facility this morning, there are no medications that they will order now. Primary care provider said if resident becomes abusive with others or tries to leave (elope), then they will address those behaviors at that time. Signature of writer unreadable

3/22/2021 at 9:47 a.m. on Friday 3/19/2021 resident became combative with staff when trying to redirect resident to her room. She was found in her neighbor's room trying to take her belongings when approached she started yelling and throwing things. Several other residents came out of the rooms to calm her down and she yelled at them also. Staff was able to finally get the resident into her own room. Resident was yelling and throwing things again in her room. Staff called her daughter to try and calm her down and it was unsuccessful. Staff attempted to call her granddaughter with no avail. Resident finally calmed down and was able to understand about her room. Health care director placed a bright colored paper with her name on her door to identify it. Resident was satisfied with that. Signed by licensed nurse C.

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S3092	Continued From page 3 5/3/2021 (no time documented) Resident continues to pack her thins and move them somewhere. She continues to go into other rooms claiming that it is her room. Resident is easily redirected. Will continue to monitor. Signed by licensed nurse C. 5/6/2021 3:38 (am/pm not documented) It was reported that on 5/5/2021 this resident was found in another resident's room and they were yelling and hitting each other. Staff were able to separate them. Family was notified and ___ was also. A referral to a behavioral unit was placed. Awaiting a call back. Signed by licensed nurse C. 5/11/2021 (no time documented) Spoke with admissions at the behavioral health facility and resident has been accepted for escalating behaviors and aggression. Durable power of attorney notified of plan and agrees with plan. Signed by licensed nurse C. 5/19/2021 at 1:45 pm, resident arrived to facility at 1:45 pm via _____, resident ambulate with unsteady gait, she shuffles at times. She does not use any assistive devices. Resident is alert to self.....Resident continues to wander the facility looking for her mother and her grandchildren. She has tried to go to the front door but was easily redirected. She continues to go door to door trying to leave or look for her family. Signed by licensed nurse C. 5/20/2021 at 9:05 am, spoke with resident's daughter last night regarding her continued behaviors. She is still going in and out of resident's room looking for her mother and grandchildren trying to go out the front door to go home, continues to say she wants to go home.	S3092		

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S3092	Continued From page 4	S3092		

Her daughter was concerned that the new medication she is taking is causing her balance to be unsteady. I explained to her daughter that her gait was starting to change right before she left. I also explained that my concern is her safety and the safety of my other residents.....

5/21/2021 (no time documented) Resident has been having a lot of loose stools. She was found sitting on her counter with her head resting against the wall asleep. Staff states she has barricaded the door. Family has been notified of behaviors and family informed me she has done that before, but the sleeping while sitting on the counter is new. I told her the resident is having more issues with her knee and it is making it hard for her to ambulate. She is using a wheelchair at this time.....Signed by licensed nurse C.

5/24/2021 (untimed late entry) It was reported by another resident to staff that resident had fallen. Reporting resident states resident was walking and lost her footing while walking and had fallen pretty hard and hit her head. Staff called on call nurse and orders to leave her there and call 911 to get her out due to head injury and resident complained of extreme pain in shoulder and elbow. Durable power of attorney notified of her fall and transfer.....(unsigned)

5/24/2021 at 2:00pm resident brought back to facility via family vehicle, Resident found to have a right scapular fracture. She is to be in an immobilizer for 4 to 6 weeks. Emergency room doctor has ordered physical/occupational therapy and sent referral to _____for gait disturbance.....Signed by licensed nurse C.

The last entry in the resident notes was completed on 6/5/2021. The resident notes

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S3092	Continued From page 5 lacked an entry for transfer to the hospital. Record review of hospital admission notes on 6/24/2021, revealed the resident had an admission diagnoses of the following: 1. found down possible fall at nursing home 2. closed traumatic non-displaced fracture of rib on right side, acute 1st non-displaced and 2nd mildly displaced, subacute 3rd, 4th and 5th and chronic rib fracture on the right side. 3. Cervical transverse process subtle non displaced fracture of cervical 6 and cervical 7 4. Major neurocognitive disorder due to multiple etiologies with behavioral disturbances 5. Addison disease 6. Advanced dementia The operator failed to ensure the negotiated service agreement for resident #1, was updated to reflect the resident changes in behaviors, unsteadiness on her feet, and the service for occupational/physical therapy as ordered after a fall with an injury.	S3092		
S3200 SS=E	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: (1) Only licensed nurses and medication aides	S3200		

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S3200	Continued From page 6 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 38 residents. The sample included 3 residents (#1, 2 and 3) and 1 focused review (#4). Based on interview and record review for resident #1 The operator failed to ensure licensed nurse C and certified medication aide A, administered medications to resident #1 in accordance with professional standards of practice related to knowing the location of medications to be administered, and to ensure the licensed nurse and medication aides administered medications as ordered and in a timely manner for resident's #2 and #3. Findings included: - Record review on 6/17/2021 for resident #1 revealed an admission date of 2/2/2021, with diagnoses of Addison disease, Cognitive disorder, insomnia, transient ischemia attack, rectal prolapse and a left bundle branch block. Record review on 6/17/2021 of the functional capacity screen dated 2/21/2021 revealed the resident lacked the ability to manager her own medications.	S3200		

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S3200	Continued From page 7 Record review on 6/17/2021 of the negotiated service agreement/health service plan identified the facility would manage her medications. Record review on 6/24/2021 of the facility June medication variance report identified the following medications which were not administered due to not being available on the dates of 6/7/2021, 6/8/2021, and 6/9/2021: Fludrocortisone 0.1 milligram tablet, Hydrocortisone 10 milligram tablet, Hydrocortisone 20 milligram tablet, Loperamide 2 milligram tablet. Record review on 6/24/2021 of the resident notes revealed a lack of entries for medications not being administered and lacked entries of notification of family/durable power of attorney and resident primary care provider being contacted. Interview on 6/17/2021 at 2:00 pm with operator B and licensed nurse C confirmed the resident did not receive the ordered medications and the medications not administered were not reported to either operator B or licensed nurse C. Operator B stated the certified medication aides are trained to notify the licensed nurse if medications are not found or administered to residents. Interview on 6/17/2021 at 2:30 pm with certified medication aide A revealed she notified medication aide D and confirmed she did not notify licensed nurse C the medications were not administered or found by certified medication aide A, and she stated she re-ordered them from the pharmacy. Interview on 6/17/2021 at 2:45 with certified medication aide D confirmed certified medication aide A reported to her that she was unable to find	S3200		

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S3200	Continued From page 8	S3200		

medications for resident #1, certified medication aide reported she told certified medication aide A where medications were located and she notified licensed nurse C of certified medication aide A not being able to locate medications.

Record review of the signed witness statements for licensed nurse C and certified medication aides A and D lack the information the medication was not administered for 3 days.

Record review of licensed nurse C signed witness statement revealed she received a phone call from the hospital nurse inquiring about medications that were not administered to resident #1. Licensed nurse C explained to the hospital nurse the medications were available and the certified medication aide was unable to find them to administer them.

The operator failed to ensure licensed nurse C and certified medication aide A administered medications to resident #1 in accordance with professional standards of practice related to knowing the location of medications to be administered.

- Record review for resident #2 revealed an admission date of 4/29/2021 with diagnoses of dementia, depression and legally blind related to poor vision.

Record review of the functional capacity screen dated 4/29/2021 revealed the resident was unable to manage his own medications.

Record review of the negotiated service agreement / health service plan dated 4/29/2021 identified / instructed facility staff to order

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S3200	Continued From page 9	S3200		

medications and the certified medication aides or licensed nurse would administer medications.

Record review of the facility medication variance report for 6/2021 revealed the following entries for medications, scheduled times and actual times administered:

Atenolol 25 milligram tablets to be administered at 6:00 pm
6/2/2021 administered at 10:48 pm
6/5/2021 administered at 7:22pm
6/12/2021 administered at 9:01 pm
6/15/2021 administered at 10:29 pm
6/16/2021 administered at 9:57 pm
6/24/2021 administered at 7:06 pm

Buspirone HCL 5 milligram tablets to be administered at 8:00 am and 5:00 pm
6/23/2021 administered at 6:07 pm
6/24/2021 administered at 11:11 am
6/24/2021 administered at 7:06 pm
6/25/2021 administered at (8 am dose) 2:26 pm
6/25/2021 administered at (5pm dose) 6:03 pm
6/26/2021 administered at 11:07 am
6/27/2021 administered at 10:00 am
6/27/2021 administered at 6:12 pm
6/28/2021 administered at 9:55 am

Desvenlafaxine succinate extended release 25 milligram to be administered at 8 pm and 8 am
6/1/2021 administered at 10:00 am
6/2/2021 administered at 11:35 am
6/3/2021 administered at 10:38 am
6/4/2021 administered at 11:53 am
6/5/2021 administered at 11:02 am
6/6/2021 administered at 9:20 am
6/7/2021 administered at 11:00 am
6/8/2021 administered at 11:00 am
6/11/2021 administered at 10:33 am

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S3200	Continued From page 10 6/12/2021 administered at 10:25 am 6/13/2021 administered at 11:33 am 6/14/2021 administered at 11:27 am 6/15/2021 administered at 11:10 am 6/16/2021 administered at 10:11 am 6/17/2021 administered at 11:40 am 6/18/2021 administered at 11:25 am 6/20/2021 administered at 9:18 am 6/21/2021 administered at 1:00 pm 6/24/2021 administered at 11:11 am 6/25/2021 administered at 2:26 pm Eliquis 2.5 milligram tablets to be administered 8:00 am and 6:00 pm 6/1/2021 administered at 10:10 am 6/2/2021 administered at 11:35 am 6/2/2021 administered at 10:48 pm 6/3/2021 administered at 10:38 am 6/4/2021 administered at 11:53 am 6/5/2021 administered at 11:02 am 6/5/2021 administered at 7:22 pm 6/6/2021 administered at 9:20 am 6/7/2021 administered at 11:00 am 6/8/2021 administered at 11:00 am 6/9/2021 administered at 10:27 am 6/10/2021 administered at 11:10 am 6/11/2021 administered at 10:33 am 6/12/2021 administered at 10:25 am 6/12/2021 administered at 9:01 pm 6/13/2021 administered at 11:33 am 6/14/2021 administered at 11:27 am 6/15/2021 administered at 11:10 am 6/15/2021 administered at 10:29 pm 6/16/2021 administered at 10:11 am 6/16/2021 administered at 9:57 pm 6/17/2021 administered at 11:40 am 6/18/2021 administered at 11:25 am 6/19/2021 administered at 10:30 am 6/20/2021 administered at 11:31 am 6/21/2021 administered at 10:48 am	S3200		

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S3200	Continued From page 11 6/22/2021 administered at 9:50 am 6/23/2021 administered at 10:19 am 6/24/2021 administered at 7:06 pm 6/25/2021 administered at 2:26 pm 6/26/2021 administered at 11:07 am 6/27/2021 administered at 10:00 am 6/28/2021 administered at 9:55 am - Record review for resident #3 revealed an admission date of 2/27/2019, with admission diagnoses of Parkinson's disease, major neuro cognitive disorder due to Parkinson's, anxiety and depression. Record review of the functional capacity screen dated 6/11/2021 revealed the resident was unable to manage his medications. Record review of the negotiated service agreement/health service plan dated 6/11//2021 identified/instructed staff to order his medications and identifies the resident will require assistance with ordering, managing and the administration of his medications. Record review of the facility medication variance report for 6/2021 revealed the following entries for medications, scheduled times and actual times administered: Abilify 2 milligram tablets scheduled for 8:00 am and 8:00 pm 6/21 2021 administered at 9:30 am Carbidopa-Levodopa 25-250 milligram tablets scheduled for 8:00 am, 11:00 am, 5:00pm and 8:00 pm 6/1/2021 administered at 12:05 pm 6/1/2021 5:00 pm dose administered at 3:43 pm 6/1/2021 administered at 9:36 pm	S3200		

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S3200	Continued From page 12	S3200		

6/2/2021 administered at 9:07 am
6/2/2021 administered at 12:54 pm
6/3/2021 administered at 9:27 am
6/3/2021 administered at 12:08 pm
6/3/2021 5:00 pm dose administered at 3:50 pm
6/3/2021 administered at 10:39 pm
6/4/2021 administered at 9:05 am
6/4/2021 administered at 12:15 pm
6/4/2021 5:00 pm dose administered at 3:28 pm
6/4/2021 administered at 10:07 pm
6/5/2021 administered at 1:00 pm
6/5/2021 administered at 10:07 pm
6/6/2021 to be administered at 2 pm, administered at 10:29 am
6/7/2021 11:00 am dose administered at 12:45 pm
6/7/2021 2:00 pm dose administered at 12:45 pm
6/8/2021 11:00 am dose administered at 2:35 pm
6/8/2021 5:00 pm dose administered at 3:55 pm
6/9/2021 administered at 12:15 pm
6/10/2021 administered at 10:00 am
6/10/2021 administered at 1:44 pm
6/10/2021 5:00 pm dose administered at 3:44 pm
6/11/2021 administered at 12:09
6/11/2021 5:00 pm dose administered at 3:47 pm
6/12/2021 administered at 1:55 pm
6/12/2021 administered at 7:34 pm
6/13/2021 administered at 1:56 pm
6/14/2021 administered at 12:21 pm
6/15/2021 5:00 pm dose administered at 9:51 pm
6/15/2021 8:00 pm dose administered at 9:19 pm
6/16/2021 administered at 1:45 pm
6/16/2021 5:00 pm dose administered at 3:40 pm
6/17/2021 administered at 12:13 pm
6/18/2021 administered at 12:06 pm
6/18/2021 administered at 9:12 pm
6/19/2021 administered at 12:35 pm
6/20/2021 administered at 12:14 pm
6/21/2021 administered at 9:30 am
6/21/2021 administered at 2:25 pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING: _____ B. WING _____	C 06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD 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
S3200	Continued From page 13 6/21/2021 5:00 pm dose administered at 3:22 pm 6/21/2021 administered at 9:43 pm 6/22/2021 administered at 12:32 pm 6/22/2021 2:00 pm dose administered at 12:32 pm 6/24/2021 administered at 12:39 pm 6/24/2021 2:00 pm dose administered at 12:39 pm 6/25/2021 11:00 am dose administered at 3:09 pm 6/25/2021 11:00 am dose administered at 2:38 pm 6/25/2021 administered at 3:09pm 6/26/2021 11:00 am dose administered at 2:46 pm 6/27/2021 11:00 am dose administered at 1:16 pm 6/27/2021 administered at 9:55 pm Review of resident signed physician orders dated 6/3/2021 revealed the following unchanged order: Carbidopa- Levodopa 25-250 1.5 tabs 5 times a day at the following times: 8:00am, 11:00am, 2:00pm, 5:00pm, 8:00 pm. Review of the resident medication administration record for may revealed the following order: give 1.5 tablets by mouth 5 times a day at 8:00am, 11:00am, 2:00pm, 5:00pm, and 8:00pm. Interview on 6/24/2021 with Operator B confirmed she was unaware of the late administration times, and when she was made aware she talked to certified medication aide E, who stated that if she has to help give cares on the floor she runs late with passing medications. Interview on 6/28/2021 with certified medication aide A revealed that she runs late passing medications due to "sometimes the residents	S3200		

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S3200	Continued From page 14 take a while to take medications and you have to stay with them". Review of the facility medication administration policy dated 4/30/2019 stated "drugs shall be administered to each resident in accordance with a physician's written order". Review of the facility missing medication policy dated 7/1/2012 stated; "staff identifying the unavailable medication will be responsible to properly document on the medication administration record and to notify the healthcare coordinator or residence director for follow up. Nurse, resident director, or designed when notified of the unavailability of the medication or treatment should notify the resident and/or legally responsible party and document the contact and comments in the resident notes. The operator failed to ensure licensed nurse C and certified medication aide A, administered medications to resident #1 in accordance with professional standards of practice related to knowing the location of medications to be administered, and to ensure the licensed nurse and medication aides administered medications as ordered and in a timely manner for resident's #2 and #3.	S3200		