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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey and complaint investigations #152854, #160510, #160730, #161026, #161699, #161738 and #162504 for the above named facility conducted on 05-19-21, 05-20-21, 05-24-21, 05-25-21 and 05-26-21.	S 000		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (a) The facility reported a census of 14 residents. The sample included 3 residents and 2 focused review. Based on observation, record review and interview the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement for 4 of 5 sampled residents (#100, #113, #129 and #332) in regards to specific details with management of insulin by injector pen, specific assistance needed for emergency evacuation, and specific	S3155		

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

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details on management of oxygen or other breathing appliances.

Findings included:

- Record review for resident #332 revealed an admission date of 03-28-2018 with diagnoses of heart disease, hypertension, cardiac pacemaker, anemia, chronic kidney disease, unspecified dementia and cognitive communication deficit.

The document titled FCS/NSA (functional capacity screen/negotiated service agreement) dated 01-20-21 identified the resident with short-term memory deficit and impaired decision making. She was unable to perform any aspects of bathing or toileting and required physical assistance with dressing, transfers, walking/mobility and used a cane or a wheelchair assistive device.

The document titled negotiated service agreement and identified by licensed nurse E as the health service plan (HSP) directed staff in the event of an emergency evacuation the resident will need assistance from nursing staff and/or emergency personnel. The HSP lacked a revision when the resident's health declined to bed ridden and would require additional assistance for an evacuation.

Review of the interdisciplinary progress notes (IDPN) revealed on 02-10-21 at 2:33 PM, the resident was seen by Hospice nurse today. The resident was very tired, dusky, flaccid and weak. On 03-04-21 at 10:19 AM resident is on comfort care.

A confidential interview with staff on 05-19-21 and 05-20-21 revealed the resident needed 2 staff if

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she needed to be transferred to a wheelchair to evacuate the facility in the event of an emergency.

Interview by email with administrator D on 05-24-21 at 3:32 PM which indicated the resident was bed bound between February and March of 2021, she was dependent on staff for all activities of daily living and was not being transferred from the bed at that time. She confirmed the HSP lacked a revision to show the resident's actual status during that time frame. She indicated the resident was in a hospital bed and would be assisted out in the bed in an emergency.

- Record review for resident #113 revealed an admission date of 05-01-2019 with diagnoses of heart disease, atrial fibrillation, anemia, diabetes type 2, chronic obstructive pulmonary disease, sleep apnea, obesity, edema and presence of an artificial eye.

The document titled FCS/NSA (functional capacity screen/negotiated service agreement) dated 02-02-21 identified the resident with intact cognition and needed physical assistance with management of medications and treatments. She was otherwise independent with activities of daily living. Under section IV Medications/Treatments/DME (durable medical equipment)/Advanced Directives licensed nurse E marked the use of oxygen and CPAP (continuouse positive airway pressure). She was not marked for the resident to self-administer all or some of her medications or treatments.

The document titled negotiated service agreement and identified by licensed nurse E as the health service plan (HSP) directed, Under

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S3155	Continued From page 3 medications it read, resident will continue to be able to recognize the medications she is taking and how often she is taking them as well as when to report any side effects. She understands what PRN means as well. The NSA/HSP lacked any information about the resident self-administering some or all her medications or treatments. Under DME section was resident uses continuous oxygen, uses a CPAP machine. The HSP lacked identification of who was responsible to manage the oxygen machine, tubing, humidifier, portable oxygen tanks or the CPAP machine for cleaning, water application for humidification and operation. Under the section for evacuation, "In the event of an emergency evacuation the resident will receive instruction/assistance from nursing staff and/or emergency personnel". The HSP lacked specifics on what kind or how much assistance the resident needed to evacuate with the use of continuous oxygen and CPAP. Observation on 05-20-21 at 6:45 PM revealed the resident in her recliner in her room with oxygen by nasal cannula. She had the following DME in the room an oxygen concentrator, CPAP, nebulizer machine, motorized wheelchair with a large oxygen tank on the back. During an interview with the resident on 05-20-21 at 6:45 PM she said she would need staff to disconnect her oxygen tubing from the oxygen concentrator or CPAP machine to the portable tank on the wheelchair for her to be evacuated. She said staff needed to unhook the oxygen tubing from the concentrator and connect to the CPAP because with her impaired eyesight she could not see the directions on the CPAP machine and she could not bend over to disconnect the tubing due to dizziness.	S3155		

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S3155	Continued From page 4 During a phone conference on 05-25-21 at 4:40 PM licensed nurse L and nurse K confirmed the HSP lacked specific directions on the management of the DME and what her assistance needs were in the event of an emergency evacuation. - Record review for resident #129 revealed an admission date of 01-26-2018 with diagnoses of congestive heart failure, hypertension, hyperparathyroidism of renal origin, bilateral spondylopathy of lumbar, diabetes type 2, age-related physical debility and bilateral osteoarthritis in hips. The document titled, FCS/NSA (functional capacity screen/negotiated service agreement) dated 01-26-21 identified the resident with impaired decision making and needed physical assistance with bathing, dressing and management of medications/treatments. Under the section for medications/treatments she is not marked as self-medicating all or some of her medications. Under DME (durable medical equipment) she is marked with oxygen use. The document titled negotiated service agreement and identified by licensed nurse E as the health service plan (HSP) directed (does not specify if resident or staff) check blood sugar levels as doctor has ordered and let them know if the levels are outside the range given by them. Give insulin per doctor's orders. The HSP does not have any specific information about what part the staff perform on the insulin or the resident performs. Under the section for DME she is marked as using oxygen with no details of who is responsible for management of the machine, tubing, humidifier if any and portable tanks if	S3155		

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used. Under the section for Evacuation-"In the event of an emergency evacuation the resident will receive instructions and/or physical assistance from nursing staff and/or emergency personnel. The HSP failed to include what or how much assistance the resident required for evacuation.

During a phone conference on 05-25-21 at 4:40 PM licensed nurse L and nurse K confirmed the HSP lacked specific directions related to administration of insulin by injector pen, directions on the management of the DME and what her assistance needs were in the event of an emergency evacuation.

- Record review for resident #100 revealed an admission date of 05-21-2019 with diagnoses of hypertension, heart failure, chronic obstructive pulmonary disease, asthma, hypertensive kidney disease, polyneuropathy, osteoarthritis of the knee, major depressive disorder and anxiety disorder.

The document titled functional capacity screen/negotiated service agreement dated 12-02-2020 identified the resident with intact cognition, independent with activities of daily living. She was able to self-administer her medications with supervision but did not self-administer her medications. She needed physical assistance for ordered treatments. She used oxygen equipment and CPAP (continuous positive airway pressure)/BiPAP (ventilator which delivers 2 levels of air pressure) machine.

The document titled negotiated service agreement identified by licensed nurse E as the health service plan directed staff to order,

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S3155	Continued From page 6 prepare, reorder and give medications and treatments. To monitor for side effects and report to the resident care coordinator when needed. Under the DME (durable medical equipment) section included the resident uses a BiPAP and continuous oxygen but did not identify who managed the use of the equipment, cleaning of the BiPAP machine, ordering of supplies, filling of the humidifier bottles if used etc. During a phone conference on 05-25-21 at 4:40 PM licensed nurse L and nurse K confirmed the HSP lacked specific directions on the management of the DME for oxygen and BiPap machine. For all of the above findings, the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement for 4 of 5 sampled residents (#100, #113, #129 and #332) in regards to specific details with management of insulin by injector pen, specific assistance needed for emergency evacuation, and specifics details on management of oxygen or other breathing appliances.	S3155		
S3171 SS=G	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	S3171		

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S3171	Continued From page 7 by: K.A.R. 26-41-204 (i) The facility reported a census of 14 residents. The sample included 3 residents and 2 for focused review. Based on observation, 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 soup served at a temperature hot enough to cause a 2nd degree burn, basic first aid for the burn. Resident #100 on 04-10-21 was served soup at the noon meal which she described as steaming hot in a Foam bowl. The soup spilled on the resident's abdomen, she activated the call pendent a total of 5 times before staff responded and when licensed nurse E arrived she failed to use standard practices for immediate first aid of the burn. The burn on 04-10-21 presented as very red and painful according to the resident and later that day had a fluid filled blister. On 04-13-21 licensed nurse E described the burn with purulent thin yellow scant drainage. On 04-16-21 the resident saw a medical care provider who prescribed an antibiotic for skin infection. The administrator also failed to ensure the facility call light system functioned properly. Residents reported long wait times for staff to respond to their calls for assistance and review of the call log revealed a system failure which had almost all call lights being reset in 30 seconds and not by staff reset when they responded at the resident's location for 8 of 14 residents (#100, #113, #129, #205, #309, #410, #439, and #506). Findings included: - Record review for resident #100 revealed an admission date of 05-21-2019 with diagnoses of	S3171		

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hypertension, heart failure, chronic obstructive pulmonary disease, asthma, hypertensive kidney disease, polyneuropathy, osteoarthritis of the knee, major depressive disorder and anxiety disorder.

The document titled functional capacity screen/negotiated service agreement dated 12-02-2020 identified the resident with intact cognition, independent with activities of daily living. She was able to self-administer her medications with supervision but did not self-administer her medications. She needed physical assistance for ordered treatments. She was marked as independent in abilities to eat.

The document titled negotiated service agreement identified by licensed nurse E as the health service plan directed staff to order, prepare, reorder and give medications and treatments. To monitor for side effects and report to the resident care coordinator when needed. Under dietary and nutrition, the service plan directed that the resident can take care of her own nutritional needs and make decisions about what she wants to eat.

During a conversation with the resident on 05-19-21 at 12:38 PM she reported having a burn on her abdomen from soup served too hot in a foam bowl which spilled onto her abdomen when she picked it up. She reported having to wait a long time more than 15 minutes for the nurse to respond to the call light. When the nurse came she did not really do anything for the burn, she did not rinse the area with cool water, apply a cold compress or any treatment until the resident told her she had some Mycitracan ointment in the bathroom. She indicated the nurse applied the Mycitracan ointment and did not cover it with any

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type of covering. The resident described the area as very red and painful which later that day had a fluid filled blister.

The lunch menu for 04-10-21 (provided by administrator D) included vegetable lasagna, tossed salad, fruited gelatin with topping, bread and a beverage. The menu did not include soup. Administrator D reported the resident had requested soup instead of the menu items. Administrator D confirmed food served to the residents' rooms were served on disposable containers.

Review of the food temperature logs for April 2021 revealed no temperature record for the soup.

Review of the call light log of the resident's pendant for 04-10-21 revealed the resident first activated the pendant at 12:10 PM with a reset of 30 seconds, activated again at 12:13 PM with a reset of 30 seconds, again at 12:15 PM with a reset of 30 seconds, again at 12:16 PM with a reset of 30 seconds and the last time at 12:17 PM with a reset of 30 seconds.

Confidential interviews with 2 direct care staff revealed the call pendants for the residents reset themselves and did not require the staff to be at the pendant to reset.

Review of the interdisciplinary progress notes (IDPN) revealed no entry dated 04-10-21. On 04-13-21 at 9:34 AM (not labeled as a late entry) licensed nurse E made an entry titled occurrence ... licensed nurse E called to resident's room. Resident had sat up and was opening the foam container which held a foam bowl of soup. The foam bowl of soup started leaking. She had a

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quarter sized red mark on her left abdomen/side ... applied some Bacitracin ointment, notified the medical care provider, administrator and resident's family member. Later that day at 2:13 PM, licensed nurse E recorded the resident's burn is healing, purulent thin yellow scant drainage. Resident is applying aloe Vera on it several times a day will continue to monitor. Size about the size of a nickel to a quarter at the worst site.

The next IDPN related to the burn was dated 04-16-21 at 10:36 AM resident had an appointment with her medical care provider for her burn ... prescribed an antibiotic for an early skin infection ...

The record included a wound assessment dated 04-16-21 at 3:52 PM which had measurements of the facility acquired burn on the resident's abdomen 2 centimeters (cm) in length but 1.5 cm in width (a quarter measures 2.4 cm circular and a nickel is 2.1 cm circular). She indicated the burn had scant serosanguineous drainage and painful. She wrote the resident's burn had a scab covering the worst part of the burn, seen by a medical care provider on 04-16-21 and started on an antibiotic for early skin infection.

Observation on 05-19-21 of photos the resident had on her personal cell phone revealed the first picture showed a raised fluid filled blister, the second picture showed the area no longer had a blister and about half the area appeared as dry dark colored skin and the 3rd picture showed improvement. The resident had a bandage on her abdomen and she did not want to remove it for observation. She said the home health wound nurse is the only person changing the bandage.

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S3171	Continued From page 11 On 05-25-21 through phone conversations and emails administrator D confirmed the facility lacked evidence of checking the temperature of the soup, the record lacked information of the licensed nurse's actions on 04-10-21 for first aid of the burn and confirmed the call light log had 5 alerts each reset in 30 seconds. She provided no additional information of a facility investigation into the occurrence or actions taken to prevent further such occurrences. Initial First Aid Treatment for minor burns, http://ameriburn.org recommended the following: Stop the burning process: cool the burn with running cool (not cold) water for at least 5 minutes, do not use ice as this may cause further skin damage ..., Remove all jewelry, watches, rings and clothing around the burned area as soon as possible Cover the burn with a sterile gauze bandage or clean cloth. Wrap loosely to avoid putting too much pressure on the burn tissue ... For small area burns, apply soothing lotions that contain aloe Vera to the burned area to help relieve the pain and discomfort. Do not use any butter, ointments or other home remedies on the burn. Such substances may trap the heat in the tissue and make the burn worse. The administrator failed to ensure health care services were provided by qualified staff in accordance with acceptable standards of practice regarding soup served at a temperature hot enough to cause a 2nd degree burn, basic first aid for the burn. Resident #100 on 04-10-21 was served soup at the noon meal which she described as steaming hot in a foam bowl. The soup spilled on the resident's abdomen, she activated the call pendent a total of 5 times before staff responded and when licensed nurse E	S3171		

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arrived she failed to use standard practices for immediate first aid of the burn. The burn on 04-10-21 presented as very red and painful according to the resident and later that day had a fluid filled blister. On 04-13-21 licensed nurse E described the burn with purulent thin yellow scant drainage. On 04-16-21 the resident saw a medical care provider who prescribed an antibiotic for skin infection.

- The resident roster provided by licensed nurse E on 05-19-21 included 14 residents and of the 8 residents with reported long call light response time 4 of the 8 had fallen in the past 180 days (#129, #205, #309, and #506).

Confidential interviews with residents on 05-19-21 and 05-20-21 revealed 5 residents who reported long call light response times as long as 15-20 minutes.

Review of the log for call light pendant alerts between 05-13-21 at 12:00 AM through 05-20-21 at 9:40 PM revealed on each of the 8 days multiple residents over the 24-hour period pushed the call light pendant to alert staff of needing assistance. Each time the log indicated the call light was reset after 30 seconds. Many of the entries reflected the resident pushed the call light pendant multiple times within a few minutes. For example, on 05-20-21 at 12:01 AM through 9:40 PM the following residents called for assistance and may or may not have received timely response based on the call light reset time of 30 seconds and the resident pushed their pendant again:
Resident #100 called 1 time with reset at 30 seconds
Resident #113 called 29 times total in 24-hour

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period, each with a reset of 30 seconds, but many were one right after another (8 times between 2:12 AM and 2:25 AM as if no staff response).
Resident #129 called 2 times with a reset of 30 seconds
Resident #205 called 7 times each reset at 30 seconds and several were a repeat call by the resident in less than a minute
Resident #309 called 3 times each reset at 30 seconds
Resident #410 called 7 times each reset at 30 seconds
Resident #439 called 1 time with a reset of 30 seconds
Resident #506 called times with each reset at 30 seconds and 3 of those were repeat calls by the resident as if the call was not answered (6:04 AM, 6:05 AM and 6:07 AM)

On 05-20-21 at 12:25 AM resident #129 pushed the call pendant and the log showed the alert paged 3 times with a total of 9 minutes and 27 seconds before reset by staff.

On 05-13-21 resident #205 pushed the pendant 7 times between 1:51 PM and 2:05 PM as if not answered (1:51 x 2, 1:55, 2:02 x 2 and 2:05 x 2). A confidential interview with a staff member revealed the resident's family member reported this incident to management because the family member was on the phone with the resident and it took 30 minutes for staff to respond.

Observation on 05-20-21 at 6:51 PM with resident #113 revealed she pushed the button on her call light pendant which immediately flashed with red indicator lights for about 30 seconds then shut off and no one was touching the pendant. At 6:54 PM direct care staff G entered the room as her call light pager was sounding. She said she just

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received the resident's call alert. She explained some of the resident's call pendants reset without staff having to come to the resident to shut them off. She demonstrated with resident #113's call light pendant of activating it, red lights flash and automatically stopped after about 30 seconds. She said the call pendants that don't automatically reset will still be flashing red when she responds to the resident and she must hold the button down for 3-5 seconds to reset and the red lights go off.

Interview with administrator D on 05-20-21 at about 7:15 PM revealed the call light pendants are worn by the resident on their wrist or around the neck. The call light pendants should flash red when activated and remain flashing until staff goes to them to reset the pendant. She did not know why the log was showing a reset at 30 seconds. She said if the resident pushed the button again it may cause it to reset but wouldn't be all of the them. The system should re-alert every 3 minutes if not reset.

During the phone conference on 05/25/21 at about 4:40 PM with administrator D and other corporate level administrative staff including licensed nurse K revealed no one had an explanation for why the call light log had almost every resident call being reset at 30 seconds. When asked if maintenance had routine preventative maintenance to check the functioning of the call light pendants and system no one knew. A request was made to review any documentation of routine monitoring for the call light system and/or service by the company who installed the system, and none was provided.

An online search for "Call light response time standard" provided the search result - in an article

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S3171	Continued From page 15 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." Review of the facility's call light pagers (alerts) policy dated 11-28-2017 directed all direct care staff, licensed nurses and administrators will have a pager on their person while on duty. The pagers must be set up to re-page and escalate to a higher level at 3-minute increments. An example was listed ... Ensure the preventative maintenance program includes testing the call system at least weekly to verify operation. The administrator failed to ensure the facility call light system functioned properly. Residents reported long wait times for staff to respond to their calls for assistance and review of the call log revealed a system failure which had almost all call lights being reset in 30 seconds and not by staff reset when they responded at the resident's location for 8 of 14 residents (#100, #113, #129, #205, #309, #410, #439 and #506). Resident #129 with a history of falling had to wait 9 minutes and 27 seconds on 05-20-21.	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	S3186		

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S3186	Continued From page 16 service and identify who is responsible for the 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 14 resident. The sample included 3 residents and 2 focused review residents. The facility indicated they managed the medications for all 14 residents. Based on observation, 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 3 residents sampled for medication management review (#100 and #113). Findings included: - Record review for resident #113 revealed an admission date of 05-01-2019 with diagnoses of heart disease, atrial fibrillation, anemia, diabetes type 2, chronic obstructive pulmonary disease, sleep apnea, obesity, edema and presence of an artificial eye. The document titled FCS/NSA (functional capacity screen/negotiated service agreement) dated 02-02-21 identified the resident with intact cognition and needed physical assistance with management of medications and treatments.	S3186		

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S3186	Continued From page 17 Under section IV Medications/Treatments/DME/Advanced Directives was not marked for the resident to self-administer all or some of her medications. The self-medication section of the admission/annual/Bi-annual/significant change assessment dated 11-27-2020 and locked/signed on 01-26-21 indicated the resident had the capability to recognize her current medications, correctly identify the medications, correctly state how frequently to take each medication and how many tablets she can take. She is capable to define PRN (as needed), administer inhaled medications without assistance, blood sugar testing and insulin pen. The document titled negotiated service agreement and identified by licensed nurse E as the health service plan directed staff to prepare the residents insulin pen, dial the prescribed dose and hand to the resident for injection. Under medications it read, resident will continue to be able to recognize the medications she is taking and how often she is taking them as well as when to report any side effects. She understands what PRN means as well. The NSA/HSP lacked any information about the resident self-administering some or all her medications. Observation on 05-20-21 at about 6:45 PM in the resident's room revealed the following medications: Tylenol extra strength tablets MiraLAX powder Dulcolax tablets DuoNeb inhalation vials (albuterol and ipratropium) for inhalation by nebulizer Budesonide inhalation vials for inhalation by nebulizer	S3186		

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Calamine clear lotion
Imodium
Desenex powder
Icy Hot rub
Zeasorb antifungal powder

During a phone conference call with administrator D and licensed nurse L confirmed the resident had the ability to manage her medications, she wanted the facility to manage some and she would manage some. Nurse L also confirmed the NSA/HSP lacked this information.

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 resident #113.

- Record review for resident #100 revealed an admission date of 05-21-2019 with diagnoses of hypertension, heart failure, chronic obstructive pulmonary disease, asthma, hypertensive kidney disease, polyneuropathy, osteoarthritis of the knee, major depressive disorder and anxiety disorder.

The document titled functional capacity screen/negotiated service agreement dated 12-02-2020 identified the resident with intact cognition, independent with activities of daily living. She was able to self-administer her medications with supervision but did not self-administer her medications. She needed physical assistance for ordered treatments.

The document titled negotiated service agreement identified by licensed nurse E as the

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health service plan directed staff to order, prepare, reorder and give medications and treatments. To monitor for side effects and report to the resident care coordinator when needed.

The self-Medication Administration assessment dated 10-30-2020 indicated the resident was capable of recognizing her current medications, identify the reason for the medication, how frequently to take the medication and to report any side effects of medications. She accurately defined PRN (as needed) use. In the notes section licensed nurse M wrote the resident safely uses Biotene mouthwash at bedside.

In the document titled, admission/annual/bi-annual, significant change assessment under section 5 self-medication licensed nurse E marked "Resident does not self-medicate".

During an interview with the resident on 05-19-21 at 12:38 PM revealed she kept some over the counter medications in her room. None of the medications were readily visible in the room and the resident had facial expression of reluctance for the surveyor to look around the room. She reported having licensed nurse E use the Mycitracan she kept in her bathroom when she was burned by spilled soup.

Interview on 05-25-21 during a phone conference with administrator D and licensed nurse K and L confirmed the NSA/HSP lacked information about the resident self-administering any medications and they would reassess and update if needed.

The administrator failed to ensure the negotiated service agreement reflected self-administration of some medications and failed to identify who was

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S3186	Continued From page 20 responsible for the administration and management of selected medications for resident #100).	S3186		
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 14 residents and the facility managed medications for all of them. Based on observation, record and interview the administrator failed to ensure a licensed nurse or a licensed pharmacist labeled over-the-counter medications for identified residents and the availability of stock medications to be used by staff for any of the residents. Findings included: - Licensed nurse E provided the resident roster	S3211		

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S3211	Continued From page 21 on 05/19/21 which indicated the facility managed medications/treatments for all 14 residents. On 05/19/21 at 10:09 AM certified medication aide (CMA) J opened the only medication cart and reported the resident's medications were stored in their rooms except for controlled substances. Observation revealed an open over-the-counter (OTC) bottle of "Tums" antacid extra strength labeled as "Stock". Observation of the medication room at 10:15 AM with CMA J and licensed nurse E revealed the following OTC medications in the upper cabinet which were not labeled with a resident's name and staff could not identify which resident the medications belonged to if any or whether the medications were a "Stock" item which could be used for all residents as follows: Tylenol Extra strength open bottle of 24 caplets A box of Salonpas medicated pain-relieving patches A box of 6 Lidocaine patches A box of cool and heat medicated patches An open unsealed foil package of albuterol with no name and no date of when the foil package was opened. An open tube of first aid antibiotic ointment 2 bottles of redness reliever eye drop The medication room cabinet also had a box and a bottle of Loperamide which had a first name and #129 written on it. Licensed nurse E reported the resident had passed away, but she did not know how long ago. Interview with licensed staff K on 05/25/21 at 4:45 PM confirmed the first and last name should be on the bottle and that residents cannot use stock medications	S3211		

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S3211	Continued From page 22 The administrator failed to ensure a licensed nurse, or a licensed pharmacist labeled over-the-counter medications for identified residents and the availability of stock medications to be used by staff for any of the residents.	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. (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 '	S3215		

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S3215	Continued From page 23 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 14 residents. The administrator failed to ensure a licensed nurse could not administer medication beyond the manufacturer's or pharmacy provider's recommended date of expiration for an opened multi-dose bottle of tuberculosis (TB) testing solution. Personnel record review revealed 4 staff were hired and possibly tested after the time frame on the open bottle of TB testing solution Finding included: - On 05/19/21 at 10:09 AM certified medication aide J opened the only medication room and medication refrigerator. Observation revealed an opened bottle of tuberculosis testing solution which had a date written on it of 10-30-2020. Licensed nurse E confirmed the date meant when the bottle was opened. Interview on 05/19/21 at 10:15 AM with licensed nurse E revealed she did not know how long it was safe to use the testing solution after opening. She lacked awareness of the shortened expiration date once the bottle was opened. She confirmed the testing solution could have been used for any newly hired staff, but she was not sure of that. The FDA (Federal Drug Administration) tuberculosis (tubersol) package insert directed	S3215		

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S3215	Continued From page 24 the tubersol testing solution would expire 30 days after the date of opening. The facility's undated policy for Medication Administration directed staff will date insulin pens, eye drops, inhalers and any medication in a multi-dose vials when opened. The administrator failed to ensure a licensed nurse could not administer medication beyond the manufacturer's or pharmacy provider's recommended date of expiration for an opened bottle of tuberculosis testing solution.	S3215		
S3216 SS=D	26-41-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist.	S3216		

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S3216	Continued From page 25 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41 205 (i) The facility reported a census of 14 residents and the facility managed the medications for all residents. Based on observation, interview and record review the administrator failed to have a system for accountability on controlled substances stored in the medication room for 1 discharged resident (#332). Findings included: - On 05-19-21 licensed nurse E provided the resident roster which indicated the facility managed the medications and treatments for all residents. On the same day licensed nurse E confirmed the facility managed the medications for discharged resident #332. On 05-19-21 at 10:09 AM certified medication aide (CMA) J opened the medication cart and a review of the controlled substance cards and accountability record revealed an accurate accounting done at each shift change. A few minutes later, CMA J opened the medication room. She unlocked an upper cabinet which had 2 cards of Lorazepam 0.5 milligrams (a controlled substance) for resident #332. One card had 29 tablets and the other card had 84 tablets. CMA J and licensed nurse E reported the medication was not verified routinely. Both staff lacked awareness the medication was being kept in the cabinet. CMA J found the individual controlled substance sheets in a stack of papers on the counter which indicated no medications were	S3216		

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S3216	Continued From page 26 missing. On 05-19-21 at 10:15 AM CMA J opened the locked refrigerator in the medication room. Observation revealed an unopened bottle of Lorazepam 2 milligram/milliliter. Licensed nurse E reporter the medication belonged to resident #332 who had passed away at the end of March 2021. She did not have a receipt or an individual controlled substance record for the medication. CMA J and licensed nurse E both said they were not counting/verifying the controlled substance at each shift change. Review of the facility's undated medication storage of drugs and biologicals directed staff ... the nurse will verify that the narcotic "count sheet" is present for all delivered narcotics (or prepare a count sheet) ... All narcotics will be counted by 2 nursing staff at each shift change ... The nurse will conduct random weekly narcotic counts to verify accuracy of count sheets and documentation ... narcotics no longer used are to be stored and counted in the narcotic storage area in the medication room until disposed. The administrator failed to have a system for accountability on controlled substances stored in the medication room for 1 discharged resident (#332).	S3216		
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,	S3320		

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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, 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 28 residents. Based on observation, interview and record review the administrator/operator failed to ensure the facility was equipped and maintained to protect the health and safety of residents, personnel and the public regarding unlocked chemicals.

Findings included:

- During the initial tour of the facility on 05-19-21 at 9:56 AM exiting off the common hallway was a room labeled Bio-Hazard. The door to the room was unlocked and freely opened when tried. Observation revealed the following items accessible to residents, personnel and the public which had cautionary statements of keep out of

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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
S3320	Continued From page 28 reach of children, harmful if swallowed. inhalation warnings, flammable and corrosive with directions to call poison control. Also, in the room were several sharp objects, tools and other items used by maintenance personnel as follows: 5 bottles of Take down Fresh and Clean concentrated enzyme cleaner with 1 of the bottles leaking a clear liquid Bottle of Vindicator disinfectant A plastic jug of citrus chisel Cleaner/degreaser A jug of carpet sanitizer Spray can of Kilz stain/mold blocker Rust prevention spray paint Spray can of Goof-Off degreaser/stain remover Contact cement glue Toilet bowl restorer Wall/texture spray Gloss protective enamel spray Klean Strip brush cleaner Coil cleaner foam (6) Insulation foam sealant spray (2) Cleaning duster spray Mineral spirits Caulking tubes (15) Various cans of paint Bottle of Betco Brite Polish While in the room making notes of the items, licensed nurse E entered and confirmed the door to the room should be locked. She checked the locking mechanism and turned the knob to locked. During a phone conference on 05-25-21 at 4:45 PM administrator D confirmed an expectation for the door and chemicals to be secured by a locked door. The facility's undated policy titled safety and security directed for chemical storage to keep	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	C 05/26/2021

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S3320	Continued From page 29 chemicals in a locked storage area away from linen or food and other combustibles. The administrator/operator failed to ensure the facility was equipped and maintained to protect the health and safety of residents, personnel and the public regarding unlocked chemicals.	S3320		