STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008013	A. BUILDING: _____ B. WING _____	C 03/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MAPLETON ANDOVER, LLC	1419 W CENTRAL AVE ANDOVER, KS 67002

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S 000	INITIAL COMMENTS The following citations represent the findings of the resurvey and complaint investigations #139471, #147664, #148435, #152331, #152836, #159828, #159895 and #160080 of the above named facility conducted on 02-09-21, 02-11-21, 02-16-21, 02-17-21, 02-18-21, 02-22-21, 02-23-21, -2-24-21, 02-25-21, 03-01-21, 03-02-21, 03-03-21, 03-04-21 and 03-08-21.	S 000		
S3028 SS=E	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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This REQUIREMENT is not met as evidenced by:
KAR 26-41-101 (F)(3)(C)(E)

The facility reported a census of 16 residents and 1 adult daycare resident. Based on record review and interview the operator failed to ensure an allegation of sexual abuse was reported by staff to the operator and the state department within 24 hours for resident #740 and failed to report an allegation to the appropriate State agency, failed to have a thorough investigation and submitted to the appropriate State agency for an alleged injury of unknown origin regarding resident #310.

Findings included:

- Record review for resident #740 revealed an admission date of 02-25-2020.

The significant change functional capacity screen (FCS) dated 10-06-2020 identified the resident with cognitive impairment in all aspects, independent with activities of daily living, had wandering and socially inappropriate/disruptive behavior with impaired decision making.

The negotiated service agreement (NSA) and health care services (HCS), reported by licensed nurse/operator G the NSA/HCS as all in 1 document the NSA, dated 10-06-2020 directed staff the resident had memory impairment and may need staff to remind her and or offer redirection at times. Staff would administer and manage the resident's medications. The resident performed activities of daily living independently and staff would prepare her meals.

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S3028	Continued From page 2 A nursing note dated 01-27-21 (no time) indicated a staff member (no name or title of staff member) reported to licensed nurse F resident #740 made statements of someone inserting objects into the resident's body cavities. The note indicated the local authorities, the medical care provider, the resident's responsible party and the state were notified. In reviewing the facility's investigation revealed notarized statements which indicated staff were aware of the resident's statements on 01-22-21 and failed to report the statements to the operator as follows: In the notarized statement by certified medication aide (CMA) B, she indicated on Saturday 01-22-21 (no time) the resident approached CMA B and asked, "Why does this keep happening to me?". CMA B asked the resident what she was talking about and the resident said someone was touching her inappropriately. The resident said a name which was unrecognizable, and CMA B said because of not having a name she did not mention anything. Then about an hour later the resident approached CMA B again and stated, "I don't know why he keeps doing this to me". ... the resident said, "he would take my pants off". CMA B indicated she talked about the resident's statements with a co-worker certified nursing assistant (CNA) A and CNA A said she had heard the resident mention someone sticking an object in her body cavity. CNA A indicated she would write the resident's statements in the daily reports. The notarized statement by CNA A indicated she witnessed the following incident involving resident #740 and the notary dated the sworn statement on 01-22-21. The body of the statement lacked a	S3028		

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date or time of the incident. CNA A wrote she saw resident #740 sitting on the couch talking with resident #447 and CNA A overheard resident #740 tell resident #447 someone had been going into her room and shoving an object into her body cavity. The statement lacked what if anything CNA A did about the statement she overheard. A second notarized statement by CNA A which the notary dated as sworn on 01-23-21 but the body of the statement lacked a date or time of the incident. CNA A wrote she saw resident #740 pull her co-worker CMA B to the side and after the conversation CMA B talked to CNA A and told CNA A what resident #740 had told her, that someone had been going into her room, touching her and putting objects in her body cavity. The statement lacked information on what if any actions CNA A took regarding the resident's statement.

The notarized statement by CMA D included, on 01-23-21 at around 3:13 PM another staff (CNA A) came to him to report resident #740 made an allegation of him touching her and putting objects in her body. CMA D indicated he had been off work from 01-16-21 through 01-22-21. CMA D wrote that he told CNA A to write a report and include that it was him being accused. The statement lacked information of any other actions taken.

Notarized statement by licensed nurse F indicated she was notified by a staff member on 01-27-21 of the resident's statements. Licensed nurse F then notified licensed nurse/operator G and other required authorities were notified.

The facility's investigation indicated the alleged perpetrator CMA D was suspended on 01-27-21 pending the outcome of the investigation.

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S3028	Continued From page 4 Interview on 02-09-21 at 1:15 PM with licensed nurse/operator G confirmed CNA A, CMA B and CMA D failed to report the resident's statement to her on 01-22-21 and /or 01-23-21. She reported gathering statements, watched the security camera footage and determined the alleged perpetrator had not been in the room. She said the resident was self-care so no reason for staff to go in her room. The operator failed to ensure an allegation of sexual abuse was reported by staff to the operator and the state department within 24 hours for resident #740. - Record review for resident #310 revealed an admission date of 03-08-2019 with diagnoses of dementia, hypertension, deep vein thrombosis (blood clot in a deep vein, usually in the legs), and edema (excess of watery fluid collecting in the cavities or tissues of the body). The admission functional capacity screen (FCS) dated 03-08-2019 identified the resident with memory deficit in long-term memory, memory/recall and impaired decision making. She required physical assistance with bathing, dressing, toileting, transfers and lacked the ability to walk. She had a risk of falls or unsteadiness, impaired vision and decision making. The negotiated service agreement (NSA) and health care services (HCS), reported by licensed nurse/operator G the NSA/HCS as all in 1 document the NSA, dated 03-08-2019 included services by the facility of meal preparation, laundry/housekeeping, assistance with bathing, grooming and dressing due to a left arm fracture	S3028		

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with a cast in place. The resident needed staff assistance with transfers due to being non-weight bearing (NWB) related to a left hip fracture. She used a wheelchair for locomotion with staff assist. On 05-16-2019 licensed nurse/operator G revised the NSA/HCS with resident used a walker to ambulate with 1 staff stand by assistance.

Review of the electronic record revealed nursing notes and incident reports which included a fall on 04-11-2019 at 3:15 PM when the resident raised her electric lift chair to high and slid down the front with no injury indicated. On 09-06-2019 at 2:05 PM the resident got herself up from the recliner, went to the bathroom and fell landing on her left knee. X-rays obtained of the left knee were suggestive of a medial tibial plateau fracture and family took the resident to the emergency room. The nursing notes indicated the resident returned to the facility the same day 09-06-2019 without interventions for the fracture. She was assisted into her recliner without signs or symptoms of pain or discomfort. On 09/12/2019 the resident saw a medical care provider, who wrote orders for the resident to wear a knee brace to the left leg at all times except showers, NWB to left lower extremity at all times for recommended 6 weeks after the injury. May perform range of motion of the left knee as tolerated in the brace and follow-up with the medical care provider in 4-6 weeks for X-rays and exam.

On 11/12/2019 licensed nurse/operator G made a report to the state through adult protective services (APS) and not the Kansas department on aging and disability services (KDADS) of the resident having ongoing issues with her leg. It had been swollen and previously been X-rayed. A family member was upset and stated the resident

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had fallen. Licensed nurse/operator G had no knowledge of when or where a fall occurred, and the resident had no bruises on her person.

Review of the NN (nursing notes) between 10-22-1019 and 11-16-2019 revealed as follows: 10-22-2019 about getting an influenza shot with the next note dated 11-16-2019. The 11-16-2019 note indicated the resident had slight swelling to the left leg and knee stating it hurt. The resident saw medical care provider R at the facility on 10-29-2019 and was treated for pain and swelling. On 10-31-29 family member K took the resident to an appointment with medical care provider S for follow-up and had an X-ray done. The resident also had a Doppler done with negative results. On 11-05-2019 staff (does not name) reported the resident had swelling to the left leg. Left leg/knee was swollen, without redness or discoloration. Medical care provider S was called and ordered "TED hose" (a brand of compression stockings) to address the swelling. Staff reported increased swelling of the left leg/knee on 11-06-2019. Hospice nurse was contacted, family member K wanted an MRI (a more detailed type of X-ray) but medical care provider S said it was not needed. Later that evening on 11-06-2019 family member K wanted EMS (emergency medical services called). ... On 11-07-2019 ... family member K reported the resident had a fractured leg and the doctor said it was not healing.

On 02-22-21 at approximately 1:15 PM licensed nurse/operator G provided the documents of her investigation for the report made to APS on 11-12-2019. The documents included a sheet from Kansas department for children and families and 5 notarized statements. The documents lacked the required state form for a narrative of

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the investigation, the outcome, actions taken and items from the resident's record related to the allegation.

The notarized statement certified medication aide (CMA) H with a notary stamp of the sworn statement obtained on 11-15-2019, indicated on the overnight shift of 10-27-2019 the resident would not stand of bear weight. CMA H indicated she spoke with the oncoming day shift staff who reported the resident was having trouble standing, bearing weight and transferring during the day of 10-27-2019. CMA H said she spoke with the resident's family member K to inquire if she should call the hospice nurse for an assessment. CMA H indicated she did not see any swelling or other signs of injury. According to the statement, the resident went to a medical care provider on 10-31-2019, had X-rays done with no new injury. On 11-06-2019 when the resident's family member K visited and hospice came for visit the hospice licensed nurse obtained an order for mobile X-ray who came and took X-rays ... the X-ray report came back, we (does not identify who "we" are) notified licensed nurse/operator G of the findings.

-Note-the facility's investigation lacked copies of any medical care provider's orders or results of any X-rays or tests.

Notarized statement by CMA J with a notary date for the sworn statement as 11-15-2019, indicated on Monday 10-28-2019 when CMA J came to work, she went to take resident #310 to the bathroom. She noticed the resident was having a hard time standing and the resident said, "It hurts, it hurts". CMA J said she started to help the resident when the family member K said, "no she can do it, stand up mom, help her", again the

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resident said, "it hurts, I can't". After the resident's shower the hospice aide asked CMA H to help due to the resident's swelling in the knee. CMA H indicated she helped transfer the resident into bed, placed a pillow under the knee. Later after lunch CMA H asked CMA D to help with the transfer from the bed to the wheelchair, when we placed the brace on for transfer. Family member K was concerned about a blood clot in the leg and a medical care provider orders a Doppler by Kansas mobile solutions who came around suppertime.

-Note-the facility investigation lacked a copy of the results for the doppler study.

Notarized statement by CMA L with a notary date for the sworn statement as 11-12-2019 indicated her first knowledge of the resident's left leg issue was on 10-30-2019 when the resident reported it was hurting. CMA L wrote she gave the resident some Tylenol and came back a little later to get the resident up, but her left leg was too swollen to put the brace on. ... Throughout the day and the next 2 days the resident complained of pain in her left leg... on Wednesday 11-06-2019 CMA L was given report that resident #310 was supposed to wear the leg brace only for transfers and to wear TED-hose (compression stockings used to manage edema). CMA L and CMA H went to get the resident up for breakfast and noted her leg was too swollen to get the TED-hose or leg brace on so they did not put them on. They got the resident dressed and assisted her to the wheelchair and then to the recliner. Family member K came to visit, hospice nurse M was called and came. Hospice nurse M obtained an order for mobile X-ray to come and do an X-ray. Family member K said CMA L needed to call an ambulance. CMA L then called licensed

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nurse/operator G who instructed CMA L to call hospice. When EMS (emergency medical services) arrived CMA L and CMA N went to transfer resident #310 to the gurney. Family member K reached down, grabbed the resident's feet to help lift her over.

In a follow up conversation with licensed nurse/operator G on 02-22-21 about the components of the investigation she reported she had provided all the documents she had.

By email on 02-23-21 at 6:34 PM the surveyor requested the X-ray results for the 09-06-19 fall, the physician's orders for 09-12-19 and any other pertinent information related to the fall with a fracture and please provide the ER (emergency room) visit notes from 11-06-19. On 02-25-21 at 4:58 PM, licensed nurse/operator G responded, I did not find any doctor's orders for the date you requested so I did pull for the closets to that date and have attached. I do not have the ER Department notes as the resident did not return to our community. On 02-25-21 at 5:28 PM the following documents for the resident were received by email: a medical care provider's order for X-ray of the left knee due to a fall dated 09-06-2019, a preliminary report from Kansas Mobile solutions which included findings suggestive of medial tibial plateau fracture with lipohemarthrosis (presence of intra-capsular floating fat in the joint cavity-traumatic knee injury most common cause), there was no final report, and a medical care provider in-facility visit note dated 09-10-2019 which included the resident wore a knee immobilizer and confirmed the resident had a left knee tibial plateau fracture.

The operator failed to report an allegation to the appropriate State Agency, failed to have evidence

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S3028	Continued From page 10 of a thorough investigation and failed to submit the report to the appropriate State agency for an alleged injury of unknown origin regarding resident #310.	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; 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 16 residents and 1 adult daycare resident. The sample included 3 residents and 8 focused review. Based on interview and record review the operator failed to ensure the written negotiated service agreement for 4 of 8 resident's (#423, #447, #730 and #818) included a description of the services the resident	S3085		

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would receive with identification of the provider for each service regarding outside providers.

Findings included:

- On 02-09-21 licensed nurse/operator G provided the resident roster which indicated resident #818 received services from an outside provider.

Record review for resident #818 revealed an admission date of 11-19-2020 with diagnoses of unspecified dementia, general anxiety disorder, hypertension, osteoarthritis, muscle weakness, unspecified fall 11-09-2020 with a displaced fracture of the greater trochanter right femur, cellulitis of the right lower limb and poor skin integrity.

The admission functional capacity screen dated 11-19-2020 identified the resident with cognitive impairment in all aspects, required physical assistance with bathing, dressing, toileting, transfers, walking/mobility and at risk for falls.

The negotiated service agreement (NSA) and health care service (HCS) (identified by licensed nurse/operator G as all in 1 document titled NSA) dated 11-19-2020 and without revisions directed staff to assist the resident with bathing, dressing, toileting and to provide supervision and cueing with transfers. She is able to ambulate for short distances with a walker and staff contact guard assistance. She also used a wheelchair for locomotion which was propelled by staff. Under the section for fall management it read, "I do have a history of falls prior to admission ..."

An undated single sheet of paper, without a title, but identified by licensed nurse F as a "care tool"

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directed staff to assist with mobility of 1 staff member. The resident had an unsteady gait, used a walker and a wheelchair. She transferred with one staff and required staff's assistance to turnover in bed and reposition. Under the section marked falls interventions, it included a history of falls with a recent right hip fracture and no revisions.

A communication with medical care provider R signed 11-25-2020 included an order for PT (physical therapy) and OT (occupational therapy) to evaluate and treat along with nursing services. The order did not specify what nursing services would be provided. The NSA/HCS and the "care tool" lacked an amendment to reflect the addition of outside provider services.

Review of the nursing notes revealed an entry on 02-15-21 (no time) which indicated the outside provider wound nurse visited and obtained a new order for a treatment to a wound on the right buttock. On 02-22-21 (no time) the nurse with an outside provider again made a visit.

The operator failed to ensure the written negotiated service agreement for resident #818 included a description of the services the resident would receive with identification of the provider for each service regarding outside providers.

- Record review for resident #730 revealed an admission date of 05-29-2020 with diagnoses of dementia, anxiety, memory and cognitive deficits, hypertension, and osteoarthritis pain.

The admission functional capacity screen (FCS) dated 05-29-2020 identified the resident with cognitive deficits in all aspects, required physical

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assistance with bathing, toileting and supervision with dressing. She had impaired vision, decision making and wandering behavior. She was not marked as at risk for falls.

The negotiated service agreement and health care services (identified by licensed nurse/operator G as all in 1 document titled NSA) dated 05-29-2020 directed staff under Walking/Mobility-"I am able to transfer without assistance from staff. I ambulate independently throughout the facility", under Falls Management-"I do have a history of falls prior to admission though my family does not recall details".

An undated and untitled single page document which licensed nurse F identified as a "care tool" directed staff to assist the resident with bathing, dressing at times, incontinent of bladder (with no specifics for toileting), independently with mobility, a history of falls (no specific interventions), anxiety and occasional aggression.

During a conversation on 02-22-21 at approximately 2:30 PM with licensed nurse/operator G she confirmed the resident received an outside provider services starting 06-09-2020 which ended on 08-03-2020 and the NSA/HCS lacked an amendment to the addition and removal of services.

The operator failed to ensure the written negotiated service agreement for resident #818 included a description of the services the resident would receive with identification of the provider for each service regarding outside providers.

- Record review for resident #447 revealed an

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admission date of 07-13-2020 with diagnoses of chronic obstructive pulmonary disease, a healing fracture of the right wrist, muscle weakness, repeated falls, urinary tract infections, restless leg syndrome, hypertension, major depressive disorder, anxiety disorder and unspecified atrial fibrillation.

The significant change functional capacity screen dated 10-05-2020 identified the resident with impaired cognition in all aspects, needed physical assistance with bathing and toileting and was at risk for falls.

The NSA dated 10-05-2020 and without revision, directed staff the resident could transfer and walk about the facility without assistance and used a walker. Under "Falls Management" - I have a history of falls prior to admission which resulted in fractures and a traumatic brain injury. I do not always use my call light because I want to do things for myself. My furniture in my room has been moved to create a clear pathway.

An undated single sheet of paper identified as a "care tool" by licensed nurse F and reviewed on 02-18-21 directed staff the resident needed assistance with bathing, dressing, used a walker and was independent with mobility. Fall intervention was marked with an X and handwritten Hx (history) of falls.

Review of the nursing notes revealed on 10-01-2020 (no time) medical care provider R visited the resident at the facility and wrote an order for PT (physical therapy) and OT (occupational therapy) to evaluate and treat. On 10-05-2020 (no time) the resident was seen by an outside provider for a PT evaluation. The NSA/HCS lacked an amendment to reflect the

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addition of a outside provider for services.

In an email communication on 02-24-21 at 6:22 PM with licensed nurse/operator G confirmed the resident received services from an outside provider between 10-05-2020 and 11-06-2020. The NSA/HCS lacked a revision for the addition and discontinuation of services the resident received.

The operator failed to ensure the written negotiated service agreement for resident #447 included a description of the services the resident would receive with identification of the provider for each service regarding outside providers.

- Record review for resident #423 revealed an admission date of 05-21-2020 with diagnoses of atrial fibrillation, mitral valve stenosis, cerebral vascular accident with hemiplegia/paresis, muscle weakness, hypertension, morbid obesity, diabetes mellitus, depression, anxiety/restlessness, COPD (chronic obstructive pulmonary disease) and pain.

The admission functional capacity screen (FCS) dated 05-21-2020 indicated the resident had intact cognition, needed physical assistance with bathing, dressing, toileting and transfers. She had occasional incontinence of bladder, lacked the ability to walk, was at risk for falls, used assistive devices of a wheelchair and a mechanical lift.

The negotiated service agreement (NSA) and health care services (HCS), reported by licensed nurse/operator G the NSA/HCS as all in 1 document the NSA, dated 05-21-2020 directed staff to provide assistance as needed for bathing, under Walking/Mobility, "I am able to transfer with

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S3085	Continued From page 16 assist using a sit-to-stand lift, to and from my wheelchair, toilet and bed". The NSA/HCS lacked directions on how much staff was needed for the activity and any cautionary requirements for the use of the lift. The NSA/HCS lacked information regarding the provision of services from an outside provider. Review of the nursing notes (NN) between 05-25-2020 and 06-25-2020 revealed the resident received services from an outside provider being documented in the first NN dated 05-25-2020 through her death 06-25-2020. The operator failed to ensure the written negotiated service agreement for resident #423 included a description of the services the resident would receive with identification of the provider for each service regarding outside providers.	S3085		
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: KAR 26-41-204 (a)	S3155		

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The facility reported a census of 16 residents and 1 adult daycare resident. The sample included 3 residents and 8 focused review residents. Based on observation, interview and record review the operator failed to ensure that 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 8 of 11 residents sampled (#231, #310, #422, #423,#447, #730, #740 and #818) regarding falls, safety with mechanical lift transfers, behaviors and elopements.

Findings included:

- Record review for resident #231 revealed an admission date at 03-24-2020 with diagnoses of dementia, hypertension, general muscle weakness, angioedema, back pain, and a personal history of a transient ischemic attack (TIA).

The significant change functional capacity screen dated 10-07-2020 indicated the resident had impaired cognition in all aspects, experienced occasional bladder incontinence and needed staff supervision with toileting.

A nursing assessment dated 10-07-2020 and identified as a significant change assessment indicated the resident had signs of genitourinary issues related to history of UTI (urinary tract infection) and used a urinal/pads/briefs but no information about the resident's abilities for toileting or personal hygiene. The assessment identified her with moderate memory loss, needed frequent reminders and supervision. Her judgment is always poor, she cannot make

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appropriate decisions for herself, she needed monitoring and guidance with decision-making. She had a history of falls, experienced weakness and used a walker. She required assistance to walk back to her room due to her diagnosis of dementia and at times required assistance with sitting to standing and standing to sitting.

The negotiated service agreement (NSA) and health care services (HCS), reported by licensed nurse/operator G the NSA/HCS as all in 1 document the NSA, dated October 10-07-2020 did not match the functional capacity as far as toileting, The NSA/HCS directed staff the resident was continent of bowel and bladder, may have urinary incontinence at time, wore underwear during the day with a pad and briefs at night. The NSA/HCS lacked any directions to staff on supervision for toileting, assistance with toileting or management of the urinary incontinence.

A single sheet piece of paper identified by licensed nurse/operator G as a "care tool" for the resident directed staff the resident needed no help with toileting, but she needed assistance with dressing, bathing, grooming and 1 staff assistance for mobility with a walker.

A nursing note dated 05-12-2020 indicated the resident was having increased incontinence and agitation. ... required encouragement to get out of bed, staff assisted the residents into clothes and the resident puts her pajamas back on. The resident ambulated independently in the room. The home health nurse obtained a specimen for urinalysis (UA) with positive results and new orders for an antibiotic were received. The note dated 05-25-2020 indicated the resident had completed the antibiotic, had no signs of a UTI and continued to have episodes of urinary

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incontinence at times. On 02-08-21 a a nursing note indicated a UA was obtained on 02-05-21 with positive results for UTI and antibiotic ordered with no mention of her continent status or toileting assistance needs.

On 02-18-21 at 11:15 AM when licensed nurse F was asked how staff knew the care needs for the residents she replied they have a "care tool".

On 02/22/21 at 1:00 PM licensed nurse/operator G confirmed staff used a "care tool" to know what the resident's care needs were.

On 02-24-21 at 6:47 PM by email, licensed nurse/operator G reported the resident needed supervision with toileting, had occasionally incontinence, wore underwear during the day with a pad and briefs at night.

The operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that meet the needs of resident #231 and were in accordance with the functional capacity screening and the negotiated service agreement related to urinary incontinence, management of the incontinence, assistance/supervision needed with toileting and personal hygiene to reduce risk of further UTIs.

- Record review for resident #310 revealed an admission date of 03-08-2019 with diagnoses of dementia, hypertension, deep vein thrombosis (blood clot in a deep vein, usually in the legs), and edema (excess of watery fluid collecting in the cavities or tissues of the body).

The admission functional capacity screen (FCS) dated 03-08-2019 identified the resident with

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memory deficit in long-term memory, memory/recall and impaired decision making. She required physical assistance with bathing, dressing, toileting, transfers and lacked the ability to walk. She had a risk of falls or unsteadiness, impaired vision and decision making.

The negotiated service agreement (NSA) and health care services (HCS), reported by licensed nurse/operator G the NSA/HCS as all in 1 document the NSA, dated 03-08-2019 which included services by the facility of meal preparation, laundry/housekeeping, assistance with bathing, grooming and dressing due to a left arm fracture with a cast in place. The resident needed staff assistance with transfers due to being non-weight bearing (NWB) related to a left hip fracture. She used a wheelchair for locomotion with staff assist. Under "Falls Management" - I (the resident) have a history of falls at home. I was at another facility and fell, which recently resulted in a fractured left arm and left hip with the handwritten word elbow and licensed nurse/operator G's initials and dated 03-08-19. The NSA/HCS lacked any directions to staff on how to reduce the risk for further falls. Under "Transfer"-I am able to transfer with assistance of 1 staff with a slide board. Toileting I need 2 staff assist with transfers. According to the resident's record she had a fall on 04-11-2019 without a revision to the NSA/HCS for interventions to reduce the risk of further falls. On 05-16-19 licensed nurse/operator G updated the NSA/HCS with discontinuation of the slide board and only 1 staff needed for toileting. On 05-16-2019 licensed nurse/operator G revised the NSA/HCS with resident used a walker to ambulate with 1 staff and stand by assistance. According to the record the resident fell again on 09-06-2019 without any revisions to the

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S3155	Continued From page 21 NSA/HCS. Review of the electronic record revealed nursing notes and incident reports which included a fall on 04-11-2019 at 3:15 PM when the resident raised her electric lift chair too high and slid down the front with no injury indicated. On 09-06-2019 at 2:05 PM the resident got herself up from the recliner, went to the bathroom and fell landing on her left knee. X-rays obtained of the left knee were suggestive of a medial tibial plateau fracture and family took the resident to the emergency room. The nursing notes indicated the resident returned to the facility the same day 09-06-2019 without interventions for the fracture. She was assisted into her recliner without signs or symptoms of pain or discomfort. On 09/12/2019 the resident saw a medical care provider, who wrote orders for the resident to wear a knee brace to the left leg at all times except showers, NWB to left lower extremity at all times for recommended 6 weeks after the injury. May perform range of motion (ROM) of the left knee as tolerated in the brace and follow-up with the medical care provider in 4-6 weeks for X-rays and exam. The NSA/HCS lacked a revision to reflect the resident's additional care needs for NWB status, use of a knee brace and ROM to the left knee and had no interventions to reduce the risk for further falls. On 02-18-21 at 11:15 AM when licensed nurse F was asked how staff knew the care needs for the residents she replied they have a "care tool". On 02/22/21 at 1:00 PM licensed nurse/operator G confirmed staff used a "care tool" to know what the resident's care needs were. By email on 02-23-21 at 6:34 PM the surveyor	S3155		

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requested the X-ray results for the 09-06-19 fall, the physician's orders for 09-12-19 and any other pertinent information related to the fall with a fracture. On 02-25-21 at 5:28 PM the following documents for the resident were received by email: a medical care provider's order for X-ray of the left knee due to a fall dated 09-06-2019, a preliminary report from Kansas Mobile solutions which included findings suggestive of medial tibial plateau fracture with lipohemarthrosis (presence of intra-capsular floating fat in the joint cavity-traumatic knee injury most common cause), there was no final report, and a medical care provider in-facility visit note dated 09-10-2019 which included the resident wore a knee immobilizer and confirmed the resident had a left knee tibial plateau fracture.

On 03-03-21 by email a request was made for the "care tool" of resident #310 and 2 other residents. On 03-03-21 at 11:50 AM licensed nurse/operator G responded, "I do not have the working tools from that time frame on any of those residents".

The operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that meet the needs of resident #310 and were in accordance with the functional capacity screening and the negotiated service agreement in regards to a known fall risk, subsequent falls and changes in her functional ability.

- Record review for resident #422 revealed an admission date of 02-25-2019 with diagnoses of dementia, anxiety, insomnia, pain and glaucoma.

The admission functional capacity screen dated 02-25-2019 identified the resident with cognitive

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impairment in all aspects, needed physical assistance from staff for bathing, dressing and toileting. Licensed nurse/operator G marked that he had wandering behavior and impaired decision making.

The nursing assessment dated 02-21-19 indicated the resident had no signs of musculoskeletal issues or a range of motion limitations. His orientation was always disoriented, required constant supervision or extensive intervention. He had poor recent memory, poor remote memory and a diagnosis of dementia. He needed monitoring and guidance with decision making. He had no signs of mobility issues with good range of motion and balance. He had no signs of transferring issues and could can transfer from supine to standing independently. He wandered within the facility, may wander outside, but does not jeopardize his health and safety. For the fall assessment he had no signs of fall issues, no history of falls and had good balance.

The negotiated service agreement (NSA) and health care services (HCS), reported by licensed nurse/operator G the NSA/HCS as all in 1 document the NSA, dated 02-25-2019 and without any revisions or changes indicated the resident was independent with transfers and ambulated independently without devices. Under Fall Management, it said I have not had any falls that have been reported by my family prior to admission. The NSA/HCS lacked information specific to the wandering behavior or interventions staff needed to implement other than the resident wearing a WanderGuard bracelet (a device which sounds an alarm if the resident goes near the received usually placed at exits).

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S3155	Continued From page 24 Review of electronic record under tab of incident reports revealed the resident had a fall on 08-17-2019 at 11:58 PM while walking around, he had another resident's walker, lost his balance and fell against the water cooler. Staff were attempting to redirect and upon approach the resident fell before staff could catch the resident. The resident was redirected, walker taken away and moved out of reach. The NSA/HCS lacked a revision to show the fall, cause of the fall and interventions needed to reduce the risk of a similar future fall. On 09-22-2019 at 11:40 AM the resident was walking down the hallway, lost his balance and fell. The incident report lacked an evaluation for causal factors or interventions to reduce the risk of further falls. The NSA/HCS lacked a revision about the fall or directions to staff. On 10-15-2019 at 3:30 PM the resident fell in his room. He had been resting prior and he fell backwards from a standing position. Staff report hearing a noise, went into the resident's room and he was lying on the floor on his back. The incident report indicated there were no objects near the resident which he may have tripped on. The incident report lacked evidence of any other causal factors for the fall and no interventions to reduce the risk for further falls. The NSA/HCS lacked a revision for the fall or interventions to reduce the risk of further falls Review of the nursing notes revealed multiple entries about behaviors of wandering, resisting care, agitation, aggression and exit seeking. The NSA/HCS lacked any identification of these behaviors or interventions/directions to staff on how to manage the behaviors. For example, an entry on 02-27-2019 resident up wandering around throughout the night ... not easily redirected when staff attempt to guide him	S3155		

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resident becomes agitated ... wandered throughout the building, attempted to go into other resident's rooms and redirected to the common areas. On 03-11-19 resident alert with confusion, became agitated when staff attempt to redirect him, continues to wander throughout the facility, wakes up in the night and attempts to wander into other resident's rooms ... resident #422 is drawn to the room another resident, will enter the room and the other resident becomes upset ... On 08-17-2019 resident had increased agitation at times, continued to walk around constantly, picked items up and placed them down in other locations ... On 09-03-2019 resident having increased agitation, continues to wander, had episodes of incontinence and resistant to staff assistance with toileting. On 09-17-2019 resident continues to have increased agitation at times, resistant to care, does not want to allow staff to assist him with dressing and changing his briefs, had increased incontinent episodes of the bladder and had 1 bowel incontinence. On 09-24-2019 continued to have increased agitation, anxiety medication changes were made, increased incontinent episodes and does not want staff to assist. On 10-14-2019 attention span is short, needs verbal cues and prompting for meals and activities of daily living ... continues to wander, resist care and staff report he is combative towards staff. Staff encouraged to re-approach later. On 10-22-2019 the resident was being aggressive towards staff and others ... resident non-compliant, will not let staff change his soiled pants or give showers. Resident has been resisting care from staff intermittently since admission, resident has been hitting ... picks up objects, relocates them, takes cushions off the furniture, pictures off the wall and becomes very angry when staff attempt to put objects back. The resident makes attempts to

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wander into other residents' rooms and is not always easily redirected. The next nursing notes dated 12-02-2019 resident discharged to home with family on 12-01-2019.

On 02-18-21 at 11:15 AM when licensed nurse F was asked how staff knew the care needs for the residents, she replied they have a "care tool".

On 02/22/21 at 1:00 PM licensed nurse/operator G confirmed staff used a "care tool" to know what the resident's care needs were.

On 02-25-21 at 4:57 PM licensed nurse/operator G replied to an email request about elopement attempts if any, WanderGuard use, behaviors if any between 10-22-2019 and 12-02-2019, the resident's inappropriate behaviors, resisting care since admission were not reflected in the NSA/HCS were there any revisions? She replied, the resident had no elopements, WanderGuard was at family's request and the only revisions or alerts would have been on the certified nursing assistant (CNA) working tools.

On 03-03-21 by email a request was made for the "care tool" of resident ##422 and 2 other residents. On 03-03-21 at 11:50 AM licensed nurse/operator G responded, "I do not have the working tools from that time frame on any of those residents".

The operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that meet the needs of resident #422 and were in accordance with the functional capacity screening and the negotiated service agreement in regards to a known wandering behavior, changes in behaviors, resisting cares, needing more

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S3155	Continued From page 27 assistance and after multiple falls to reduce the risk for further falls. - Record review for resident #423 revealed an admission date of 05-21-2020 with diagnoses of atrial fibrillation, mitral valve stenosis, cerebral vascular accident with hemiplegia/paresis, muscle weakness, hypertension, morbid obesity, diabetes mellitus, depression, anxiety/restlessness, COPD (chronic obstructive pulmonary disease) and pain. The admission functional capacity screen (FCS) dated 05-21-2020 indicated the resident had intact cognition, needed physical assistance with bathing, dressing, toileting and transfers. She had occasional incontinence of bladder, lacked the ability to walk, was at risk for falls, used assistive devices of a wheelchair and a mechanical lift. The negotiated service agreement (NSA) and health care services (HCS), reported by licensed nurse/operator G the NSA/HCS as all in 1 document the NSA, dated 05-21-2020 directed staff to provide assistance as needed for bathing twice a week without any specifics on how much assistance the resident needed with 1 side of her body paralyzed. Under Toileting, "I (the resident) am mostly continent of bowel and bladder but use briefs provided by my family for my urinary incontinence". The NSA/HCS lacked any directions to staff on when or how the resident needed assistance with toileting. Under Walking/Mobility, "I am able to transfer with assist using a sit-to-stand lift, to and from my wheelchair, toilet and bed". The NSA/HCS lacked directions on how much staff was needed for the activity and any cautionary requirements for the use of the lift.	S3155		

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S3155	Continued From page 28 Review of the nursing notes (NN) between 05-25-2020 and 06-25-2020, skilled nursing notes (SNN) and physical therapy (PT) notes during the same time frame revealed after family members returned to another country the resident began having a health decline, a mood/depression change, refusal of therapy services, needed more assistance with activities of daily living, increased incontinence, not participating in transfers with the sit-to-stand lift. For example: NN 05-25-2020 indicated the resident required encouragement to get up at times. Resident does not attempt to participate with the sit-to-stand transfer and will hang in the sling. Resident is currently working with therapy. Beginning 06-05-2020 and 06-08-2020 the residents started having some changes in her health with low potassium and low blood sugar which required EMS (emergency medical services). On 06-11-2020 she was started on Remeron 7.5 milligram daily for a mood enhancer. On 06-19-2020 she began showing even more of decline, not wanting to get out of bed, only wanting to eat fast food and not eat the food provided from the facility. She was incontinent of her bowel and bladder by not alerting staff of her need to toilet. She does not make any effort to participate in the transfers with the sit-to-stand lift. On 06-22-2020 the home health nurse had a discussion with the resident and resident's family about her lack of progress and the option of Hospice. Review of the SN notes and PT notes revealed the same information reflecting a decline in the overall abilities of the resident. For example: PT notes 06-01-2020 resident able to sit on edge of bed independently after assisted into a sitting position and maintained for 2.5 minutes and on 06-04-2020, resident only partially compliant with home exercises. She does not seem to be	S3155		

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participating in transfers or try to stand in the sit-to-stand lift.

-Note-during the resident's decline and changes in abilities the record lacked evidence of a licensed nursed completing a significant change FCS and/or any revisions to the NSA/HCS directing staff in the additional needs of the resident.

On 02-18-21 at 11:15 AM when licensed nurse F was asked how staff knew the care needs for the residents, she replied they have a "care tool".

On 02/22/21 at 1:00 PM licensed nurse/operator G confirmed staff used a "care tool" to know what the resident's care needs were.

On 03-03-21 by email a request was made for the "care tool" of resident #423 and 2 other residents. On 03-03-21 at 11:50 AM licensed nurse/operator G responded, "I do not have the working tools from that time frame on any of those residents".

The operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #423 and were in accordance with the functional capacity screening and the negotiated service agreement in regards to assistance needs with bathing, toileting, personal hygiene, safety with the sit-to-stand lift and after exhibiting a decline in health and functional abilities.

- Record review for resident #447 revealed an admission date of 07-13-2020 With diagnosis of chronic obstructive pulmonary disease a healing fracture of the right wrist muscle weakness

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repeated falls urinary tract infections restless leg syndrome hypertension major depressive disorder anxiety disorder an unspecified atrial fibrillation

The significant change functional capacity (FCS) dated 07-13-2020 identified the resident with cognitive impairment in all aspects, she required physical assistance with bathing and at times toileting. She was usually continent of bladder identified and identified as a fall risk with the use of a walker, had impaired hearing and decision making.

The negotiated service agreement (NSA) and health care services (HCS) (identified by licensed nurse/operator G as an all in 1 document titled NSA) dated 07-13-2020 and without a revision, directed staff under Walking/Mobility- "I (the resident) am able to transfer without assistance from staff. I ambulate independently throughout the facility with a walker. Under "Falls Management"-I do have a history of falls according to my family.

Review of the electronic record revealed on 09-20-2020 at 7:30 PM a staff member was walking in the hallway and heard the resident call out "I need you". The resident had fallen in her bathroom and was able to get herself up to the couch. The resident had bruising to her forehead with no other injuries and was given an ice pack. Family was notified and declined having the resident go to the emergency for evaluation even with the large hematoma on her forehead. The NSA/HCS lacked a revision to reflect this fall, causal factors and interventions developed to reduce the risk for further falls.

The significant change FCS dated 10-05-2020

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was marked the same for cognition and ADL abilities as the previous FCS dated 07-13-2020 and she was still identified as a fall risk.

The NSA dated 10-05-2020 and without revision, directed staff the resident could transfer and walk about the facility without assistance and used a walker. Under "Falls Management" - I have a history of falls prior to admission which resulted in fractures and a traumatic brain injury. I do not always use my call light because I want to do things for myself. My furniture in my room has been moved to create a clear pathway.

An undated single sheet of paper identified as a "care tool" by licensed nurse F and reviewed on 02-18-21 directed staff the resident needed assistance with bathing, dressing, used a walker and was independent with mobility. Fall intervention was marked with an X and handwritten Hx (history) of falls. No interventions/directions to reduce the risk of further falls were included.

The record reflected the following falls for the resident without clear causal factors and revisions to the NSA/HCS to reduce the risk for further falls:
10-15-2020 at 12:53 PM, resident was trying to get to the table for lunch and her 4-wheel walker slipped out from under her. The resident had some bruising to her right hand.
10-17-2020 at 8:36 AM, staff went to check on the resident and found her on the floor of the bathroom. The resident stated she slipped while trying to go to the bathroom.
10-22-2020 at 4:22 PM, staff member found the resident on the floor between her window and the bed. The resident said she was looking for a drink of water and ended up on the floor.

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S3155	Continued From page 32 11-08-2020 at 3:27 PM, staff found the resident in her room on the floor. Resident stated she was looking for her briefs, slipped and fell. No injury per staff. 01-15-21 at 5:00 PM, staff assisted the resident to the bathroom, staff turned their back on the resident to open the bathroom door and when staff turned around the resident had fallen into the closet. The staff member told the resident not to move and went to notify the nurse. Resident complained of shortness of breath, back pain and a skin tear on her right forearm. The medical care provider was notified, ordered a chest X-ray, PRN (as needed) pain medication and skin tear was cleansed and left open to air. 02-07-21 at 5:02 AM, staff member found the resident next to the bathroom on the floor. Resident stated she went to the bathroom and missed the chair on her way back. 02-13-21 at 7:30 AM, staff report the resident had been resting in bed. The resident state she was getting up, had gone to get something and on her way back to sit in the chair she went down on her knees in front of her chair. Staff report the resident was kneeling on her knees in front of her recliner. Observation on 02-18-21 at approximately 11:30 AM revealed the resident sat on the couch in the common area with a 4-wheeled walker beside her. A few minutes later CMA P encouraged the resident to stand up, walk with the walker and cueing or guiding by CMA P into the dining room for lunch. On 02-23-21 an email request for information regarding interventions developed and put in place after each of the above falls to reduce the risk of further falls resulted in no other information provided.	S3155		

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S3155	Continued From page 33 The operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #447 and were in accordance with the functional capacity screening and the negotiated service agreement in regards to interventions to reduce the risk for further falls. - Record review for resident #730 revealed an admission date of 05-29-2020 with diagnoses of dementia, anxiety, memory and cognitive deficits, hypertension, and osteoarthritis pain. The admission functional capacity screen (FCS) dated 05-29-2020 identified the resident with cognitive deficits in all aspects, required physical assistance with bathing, toileting and supervision with dressing. She had impaired vision, decision making and wandering behavior. She was not marked as at risk for falls. The negotiated service agreement and health care services (identified by licensed nurse/operator G as an all in 1 document titled NSA) dated 05-29-2020 directed staff under Walking/Mobility-"I am able to transfer without assistance from staff. I ambulate independently throughout the facility", under Falls Management-"I do have a history of falls prior to admission though my family does not recall details". The NSA/HCS lacked interventions to reduce the risk for further falls. The NSA/HCS lacked any information about the resident's wandering behavior or risks associated with the behavior. An undated and untitled single page document which licensed nurse F identified as a "care tool" directed staff to assist the resident with bathing,	S3155		

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dressing at time, incontinent of bladder (with no specifics for toileting), independently with mobility, a history of falls (no specific interventions), anxiety and occasionally aggression. Updated on 06/20/2020 with the words "Elopement risk" and no specific interventions.

Review of the electronic record revealed an incident on 06-20-2020 at 1:50 PM of wandering and left the facility without staff's knowledge. The resident was visiting with another resident in the common area and walking around. A visiting family member went out the side door of the facility and resident #730 walked out with another resident #740 out the side door behind the visiting family member. The resident walked a block away and told a bystander they were being held against their will. The bystander called local law enforcement who returned residents #730 and #740 about 10-15 minutes later.

The significant change FCS dated 10-06-2020 identified the resident with cognitive deficit in all aspects, required physical assistance with bathing, dressing and toileting. She was at risk for falls, had impaired vision, impaired decision making and wandering behavior.

The NSA dated 10-06-2020 and without revision, directed staff the resident could transfer and ambulate independently without an assistive device. Under Falls Managemnt - I have not had any falls for more than a year according to my family. However, the FCS identified the resident with a fall risk and the NSA/HCS lacked any interventions to reduce the risk of future falls. The NSA/HCS lacked information to address the resident's wandering behavior or use of a WanderGuard.

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The medication administration record provided included a WanderGuard bracelet with directions for staff to check every shift and look for the flashing red light.

Review of the electronic record revealed an non-injury incident report not defined as a fall dated 02-08-21 at 9:00 AM which indicated a staff member notified licensed nurse F the resident had rolled off the living room couch during the night (Webster's dictionary defined a fall as move downward, typically rapidly and freely without control, from a higher to a lower level). The NSA/HCS lacked identification of the fall, causal factors or interventions to reduce the risk for further falls. Also on 02-08-21 at 11:00 AM CMA O entered the resident's room and found the resident on the floor. The resident was previously in bed and when asked what happened the resident did not say. Staff assisted the resident off the floor, back into bed and moved the bed against the wall. The NSA/HCS lacked a revision to reflect the fall and interventions to reduce the risk for further falls.

Observation on 02-18-21 at about 11:30 AM revealed CMA O and CMA P assisted the resident to ambulate from the living room to the resident's room providing standby assistance, directions and cueing.

On 02-24-21 at 6:47 PM licensed nurse/operator G responded to the email request about interventions to address the falls as, "the FCS and NSA will be revised to correctly identify the risk for falls".

The operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the

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needs of resident #730 and were in accordance with the functional capacity screening and the negotiated service agreement in regards to interventions to reduce the risk for further falls and to address her wandering behavior.

- Record review for resident #740 revealed an admission date of 02-25-2020 with diagnoses of dementia, anxiety/agitation, aggressive behavior, depression, hypertension and pain.

The admission functional capacity screen (FCS) dated 02-25-2020 identified the resident with cognitive deficit in all aspects and independent with ADLs (activities of daily living such as bathing, dressing, toileting, transfers, walking/mobility and eating). The section for current or recent problems and risks was marked with only impaired decision making.

The negotiated service agreement and health care services (identified by licensed nurse/operator G as an all in 1 document titled NSA) dated 02-25-2020 and without revision included services of meal preparation, housekeeping/laundry, medication management and the resident was independent with ADLs. She had memory impairment and her family member would assist with major decision. The NSA/HCS lacked any information about resident having aggressive behavior (as diagnosed) or directions to staff on how to manage the resident's behavior.

A nursing note date 03-03-2020 (no time) included; resident up ad lib (as desires) without assistance, required redirection due to aggressive behavior and agitation. Resident became very upset and confused at times about placement

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and does not remember where she lives and asks driver to take her places. Resident does not always calm down easily and will pace in hallway at times. The next note dated 03-10-2020 (no time) medical care provider R visited with new orders for Depakote 125 milligrams by mouth twice a day for aggressive behavior. The notes between 03-23-2020 and 06-18-2020 were suggestive of attention seeking behaviors. She would act like she could not eat when staff were watching but later eat independently. Resident would act like she was going to fall and then gently put herself on the floor.

Incident report dated 06-20-2020 indicated the resident left the facility without staff's knowledge by following a visiting family member out the door. The resident walked to a nearby area across the street and told a bystander she was being held against her will. The bystander called local law enforcement and the resident was returned to the facility. The NSA/HCS lacked a revision to reflect the resident's elopement risk and interventions to reduce the risk for further elopements.

The significant change FCS dated 08-11-2020 reflected the resident continued with the same cognition and ADL abilities. She now had wandering and socially inappropriate/disruptive behaviors marked on the FCS and no new NSA/HCS was provided for 08-11-2020 and the 02-25-2020 NSA/HCS lacked a revision to reflect these behavioral changes.

The significant change FCS dated 10-06-2020 indicated the same cognition, ADL abilities, wandering and socially inappropriate behaviors. The NSA/HCS dated 10-06-2020 lacked any identification or interventions for management of wandering or socially inappropriate behavior.

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S3155	Continued From page 38 Review of the nursing notes between 06-26-2020 and 11-25-2020 revealed multiple entries which included medical care provider visits with medication changes to manage behaviors. On 12-02-2020 the resident voiced having thoughts of suicide and she had a medical care provider visit on 12-03-2020 with no revision to the NSA/HCS. On 12/17/2020 the medical care provider adjusted the resident's medications. On 12/22/2020 in the dining room the resident spoke unkind things to other residents. On 12/28/2020 a telemed visit between the resident and medical care provider R about recent behaviors of hitting and grabbing other residents or talking foul to other residents ... The NSA/HCS lacked any revisions to direct staff in how to manage the resident's behaviors. An entry dated 01-07-21 (no time) indicated the medical care provider visited and discussed the resident's recent behaviors with a medication change ... On 02-18-21 at 11:15 AM when licensed nurse F was asked how staff knew the care needs for the residents she replied they have a "care tool". On 02/22/21 at 1:00 PM licensed nurse/operator G confirmed staff used a "care tool" to know what the resident's care needs were. A request on 02-18-21, 02-22-21 and 02-23-21 to provide the "care tool" for the resident resulted in none provided. An email received on 06-24-21 at 6:22 PM from licensed nurse/operator G included this response to questions about behavioral interventions or services "we do not have any behavioral "care plan" interventions because we do not do "care plans" as it is not an assisted living regulation.	S3155		

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We have nurses notes documenting any behavior concerns which are then followed up by licensed nurse F, then if need be we will request a visit from medical care provider R to review for any further instructions".

The operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #740 and were in accordance with the functional capacity screening and the negotiated service agreement in regards to interventions to address her socially inappropriate behavior, wandering behavior, elopement risk and thoughts of suicide.

- Record review for resident #818 revealed an admission date of 11-19-2020 with diagnoses of unspecified dementia, general anxiety disorder, hypertension, osteoarthritis, muscle weakness, unspecified fall 11-09-2020 with a displaced fracture of the greater trochanter right femur, cellulitis of the right lower limb and poor skin integrity.

The admission functional capacity screen dated 11-19-2020 identified the resident with cognitive impairment in all aspects, required physical assistance with bathing, dressing, toileting, transfers, walking/mobility and at risk for falls.

The negotiated service agreement (NSA) and health care service (HCS) (identified by licensed nurse/operator G as an all in 1 document titled NSA) dated 11-19-2020 and without revisions directed staff to assist the resident with bathing, dressing, toileting and to provide supervision and cueing with transfers. She is able to ambulate for short distances with a walker and staff contact

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S3155	Continued From page 40	S3155		

guard assistance. She also used a wheelchair for locomotion which was propelled by staff. Under the section for fall management it read, "I do have a history of falls prior to admission ..." The NSA/HCS lacked interventions to reduce the risk for further falls.

An undated single sheet of paper, without a title, but identified by licensed nurse F as a "care tool" directed staff to assist with mobility of 1 staff member. The resident had an unsteady gait, used a walker and a wheelchair. She transferred with one staff and required staff's assistance to turnover in bed and reposition. Under the section marked falls interventions, it included a history of falls with a recent right hip fracture with no specific interventions to reduce the risk for future falls and no revisions.

Review of the electronic record revealed 3 incident reports of the resident falling from the bed as follows and none were updated on the NSA/HCS with interventions to reduce the risk for further falls:
12-10-2020 at 1:15 AM Staff found the resident on the floor next to her bed on her right side. Staff recorded it looked like she tried to get up without assistance. The resident did not use the call light. Staff recorded she was very confused and anxious. The resident sustained a skin tear on the right arm at the elbow which was cleansed and wrapped with gauze dressing. Staff assisted up and to the recliner. The resident denied pain and did not recall what happened.
01-23-21 at 3:13 PM, certified nursing assistant (CNA) Q wrote the resident was trying to get out of bed by herself. CNA Q assisted the resident who was about to fall out of the bed then left to go help another resident. When CNA Q finished with the other resident and came back down the hall

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S3155	Continued From page 41 she found resident #818 had fallen out of bed. The resident sustained a skin tear to the right wrist. 02-05-2021 at 9:47 PM CNA A made rounds down the hall and heard the resident yelling for help. CNA A found the resident in her room, she had fallen off the bed and was sitting on the floor. On 02-18-21 at 11:15 AM when licensed nurse F was asked how staff knew the care needs for the residents, she replied they have a "care tool". On 02/22/21 at 1:00 PM licensed nurse/operator G confirmed staff used a "care tool" to know what the resident's care needs were. An email request on 02-23-21 for interventions developed and implemented with each of the above falls resulted in no additional information provided in the email response by licensed nurse/operator G on 02-24-21 at 6:22 PM. The operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of resident #818 and were in accordance with the functional capacity screening and the negotiated service agreement in regards to interventions to reduce the risk for further falls.	S3155		
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.	S3202		

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S3202	Continued From page 42 This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d)(4) The facility reported a census of 16 residents and 1 adult daycare resident. Licensed nurse/operator G reported facility certified medication aides (CMAs) performed blood sugar testing on residents. Based on interview and record review the operator failed to ensure a licensed nurse oriented and instructed 3 of 3 sampled CMAs (CMA B, CMA D, and CMA E) in the performance of blood sugar testing, and failed to document a demonstration of the competency signed by the nurse and the CMA in each employee's personnel record. Findings included: - On 02-09-21 at 2:45 PM licensed nurse/operator G and licensed nurse F reported the facility certified medication aides (CMAs) were delegated to perform resident blood sugar testing as ordered. Neither nurse identified residents who needed facility CMAs to obtain their blood sugar testing. Review of the personnel file for CMA B revealed a hire date of 01-07-21 and no evidence of training or competency in performing blood sugar testing. Review of the personnel file for CMA D revealed a hire date of 05-28-19 and no evidence of training or competency in performing blood sugar testing. Review of the personnel file for CMA E revealed a hire date of 01-08-21 and no evidence of training or competency in performing blood sugar testing.	S3202		

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S3202	Continued From page 43 Review of the record for resident #631 revealed CMA D initialed obtaining the resident's blood sugar. On 02-15-21 at 11:13 AM and again on 02-16-21 at 9:47 AM in an email licensed nurse/operator G reported licensed nurse F said the CMAs receive training in the CMA course (see below for what the CMA curriculum stated). She indicated a licensed nurse will go over the blood sugar testing when the CMA is oriented to the medication cart. The certified medication aide curriculum last updated 2011 included, Glucometer testing requires use of electronic devices that can analyze the test strip and give a numerical readout of the glucose level. A finger is pricked with a lancet, a drop of blood is placed on test strip and placed in the machine for analysis. The machine gives an immediate blood sugar result. (Normal blood sugar level 60-110 mg/dl.). A medication aide in the state of Kansas should refuse to perform test unless he/she is properly trained. Medication aides must be trained and found to be competent before performing glucose testing. Refer to information regarding Nurse Delegation at Kansas Department on Aging's website. The operator failed to ensure a licensed nurse oriented and instructed 3 of 3 sampled CMAs (CMA B, CMA D, and CMA E) in the performance of blood sugar testing, and failed to document a demonstration of the competency signed by the nurse and the CMA in each employee's personnel record.	S3202		

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S3211	Continued From page 44	S3211		
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 16 residents and 1 adult daycare resident. The operator reported facility management of medications for all residents Based on observation and staff interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on over the counter (OTC) medications and failed to write the name on both the original manufacture's package of OTC medication and the container, bottle, or tube which could be removed from the original package. This deficient practice affected residents #231, #269, #305, #314, #447, #513, #518, #572, #612 and #818. Findings included:	S3211		

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S3211	Continued From page 45 - On 02/09/21 licensed nurse/operator G provided a resident roster which identified the facility managed medications for all 17 residents. On 02/09/21 at 2:08 PM certified medication aide (CMA) D opened the medication cart for the 1513 house. Observation revealed the following over the counter medications (OTC) labeled as "stock", or had no name or without labeling of the full name as follows: A partial tube of Aspercreme without a name on it. CMA D identified it as belonging to resident #305. An open bottle of aspirin 81 milligrams (mg) with the first name of resident #305 written on the lid. A open partial bottle of acetaminophen 500 mg labeled with a partial of resident #314's first name and a room number An open bottle of zinc complex with no name and CMA D did not know who the OTC belonged to. An open bottle of calcium with vitamin D and an open bottle of acetaminophen 500 mg which had resident #269's first name, first initial of the last name and a room number. A bottle of Mucinex labeled with resident #269's first name and room number. Resident #518 had 6 bottles of OTC medications all were labeled with the resident's first name only. An open bottle of Omega XL with resident #513's first name and first initial of the last name written on it. A bottle of stomach relief with the first name of resident #513 written on it. An open tube of cold sore ointment with the first name of a resident that did not match any current residents and a room number. A bottle of Centrum silver with no name The cart had the following OTC medications labeled or identified by CMA D as stock: acetaminophen 650 mg (8-hour arthritis),	S3211		

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ibuprofen 200 mg, acetaminophen 500 mg, Zyrtec, and witch hazel.

On 02-09-21 at 2:30 PM CMA D opened the medication cart for 1419 house. Observation revealed the following OTC medications without a name, only a first name, a room number or bottle of medication separated from the manufacture original package and not labeled:
An open bottle of acetaminophen 500 mg without a name but had an address label on the bottle and CMA D identified the meds as belonging to resident #818 and the address label was the resident's family.
A bottle of Benadryl with resident #231's first name and room number
A Ziplock type clear plastic bag with resident #572's full name. Inside the plastic bag was an opened bottle of Thera-tears with no name on it.
A tube of "bruise relief" with resident #447 last name. In the bottom of the cart was an open box of Senna 8.6 mg that had the first name of resident #447 and a room number which did not match resident #447's current room number.
An opened box of Icy Hot patches with resident #612's first name.

Interview with licensed nurse/operator G on 02-09-21 at 2:50 PM confirmed the OTC medications needed to be labeled with the resident's full name.

The operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on over the counter (OTC) medications and failed to write the name on both the original manufacture's package of OTC medication and the container, bottle, or tube which could be removed from the original package. This deficient practice affected

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S3211	Continued From page 47 residents #231, #269, #305, #314, #447, #513, #518, #572, #612 and #818.	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 ' s or pharmacy provider ' s recommended date of expiration.	S3215		

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S3215	Continued From page 48 This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (h)(1) The facility reported a census of 16 residents and 1 adult daycare resident. The facility reported management of medications for all residents except #930. Based on observation and interview the operator failed to ensure only licensed nurses and medication aides had access to the stored medications and biologicals in the 1513 house. Findings included: - Observation on 02-09-21 at 2:08 PM revealed certified medication aide (CMA) D pushed open the unlocked half door into the staff work area at the side of the kitchen. He obtained a set of keys on a lanyard which he identified as the keys to the medication cart. A non-licensed or certified medication aide was in the kitchen area cleaning up. Interview on 02-09-21 at 2:08 PM with CMA D revealed he routinely placed the keys there when he was down the hall doing cares or cleaning. A discussion took place with licensed nurse/operator G and licensed nurse F on the regulation requirement for securing the keys to the medication storage and they confirmed the requirement. The operator failed to ensure only licensed nurses and medication aides had access to the stored medications and biologicals.	S3215		

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S3270	Continued From page 49	S3270		
S3270 SS=F	26-41-104 (b) Written Emergency Plan (b) Each administrator or operator shall ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including the following: (1) Fire; (2) flood; (3) severe weather; (4) tornado; (5) explosion; (6) natural gas leak; (7) lack of electrical or water service; (8) missing residents; and (9) any other potential emergency situations. This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (b)(2)(3)(4)(5) The facility reported a census of 16 residents and 1 adult daycare resident. Based on record review and interview the operator failed to develop a detailed written emergency management plan to manage potential emergencies and disasters as required for flooding, severe weather, tornado, and explosion with the potential to affect all residents. Findings included: - Review of the disaster plan notebook provided by licensed nurse/operator G on 02/09/21 revealed a 19-page document with the first page being the facility floor plan, exits, extinguisher, exit signs and lights. The next page began the "Emergency Handbook" which lacked any	S3270		

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S3270	Continued From page 50 directions to staff or residents on what to do in the event of flooding, severe weather, tornado or explosion. While talking about the disaster plan notebook with licensed nurse/operator G on 02-09-21 she reported the emergency handbook is what they have for the disaster plan. The operator failed to develop a detailed written emergency management plan to manage potential emergencies and disasters as required for flooding, severe weather, tornado, and explosion with the potential to affect all residents.	S3270		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced	S3280		

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S3280	Continued From page 51 by: KAR 26-41-104 (d) (3) The facility reported a census of 16 residents and 1 adult daycare resident. Based on interview and record review the operator failed to ensure staff and residents had disaster and emergency preparedness by a failure to conduct a quarterly review of the facility's emergency management plan. Findings included: - On 02-24-21 at 6:47 PM licensed nurse/operator G provided documentation by email to a request for evidence of quarterly review with residents and staff of the facility's emergency management plan. Review of the documents provided revealed a single sheet of paper for 1 employee dated 04-27-2019 which included some questions related to fire and the safety book answered by a single employee. The second document was titled, Staff meeting/mini in-service dated 04-14-2020 which had 19 employee signatures and indicated Fire and Safety "RACE", fire/safety handbook was reviewed. The other pages in the email were 4 pages of Monthly fire drill report (2 pages per each house, 1419 and 1513) which include the annual evacuation done 09-30-19 and 04-30-20. The administrator failed to ensure staff and residents had disaster and emergency preparedness by a failure to provide information for a quarterly review on the facility's emergency management plan.	S3280		

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S3395	Continued From page 52	S3395		
S3395 SS=E	28-39-255 LAUNDRY (c) Laundry facility. (1) The facility shall store soiled laundry in a manner which prevents odors and spread of disease. (2) If laundry is processed in the facility, the facility shall provide washing and drying machines. The facility shall arrange the work area to provide a "one-way flow" of laundry from a soiled area to a clean area. (3) The facility shall provide a work counter and a locked cabinet for storage of chemicals and supplies. (4) The facility shall provide a handwashing lavatory with a non-reusable method of hand-drying within or accessible to the laundry facility. This REQUIREMENT is not met as evidenced by: KAR 28-39-255 (c)(3) The facility reported a census of 7 residents in the 1419 house. Based on observation, interview and record review the operator failed to ensure the laundry area had locked cabinets for storage of chemicals and supplies. Findings included: - During the entrance tour on 02/09/21 at 12:28 PM the door to the facility laundry room freely opened. Observation revealed on the counter was a spray bottle of Febreze with a warning label	S3395		

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S3395	Continued From page 53 accidentally consumed seek medical attention immediately, a box of dryer sheets labeled keep out of reach of toddlers/pets and in the unlocked cabinet was a spray bottle of fabric sanitizer. Interview on 02/09/21 at 12:37 PM with licensed nurse/operator G confirmed the chemicals needed to be secured and that the facility had cognitively impaired residents who wandered. The operator failed to ensure the laundry area had locked cabinets for storage of chemicals and supplies.	S3395		