STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey on the above named home plus facility for complaint #152626 conducted on 05/20/2020, 05/21/2020, 05/26/2020, 05/27/2020 and 05/28/2020.	S 000		
S5028 SS=E	26-42-101 (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 home 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. This REQUIREMENT is not met as evidenced	S5028		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5028	Continued From page 1 by: KAR 26-42-101 (f) (3) (A)(B)(C) The facility reported a census of 6 residents. The sample included 4 residents. Based on observation, interview and record review the operator failed to ensure each allegation of abuse, neglect or exploitation was reported to the department within 24 hours. The operator failed to meet the requirements for each allegation of starting an investigation, taking immediate actions to prevent further abuse, neglect or exploitation while the investigation was in progress and ensuring each allegation had a thorough investigation for 2 of 4 sampled residents (#9) who alleged rough treatment, resident (#8) with an injury of unknown origin and missing controlled substance for 1 or more unnamed residents. Findings included: - During the entrance meeting on 05/20/2020 beginning at 1:58 PM operator F reported resident #9 a while back made an report of mistreatment by a staff member. Operator F said she worked with the resident's case manager for the state insurance payor to resolve the resident's concern. The operator provided a folder of the documents associated with the allegation. Noted within the documents was an email dated 4/12/2020 at 2:25 PM to the state insurance payor about a conversation regarding the report of a staff member to resident incident. The email indicated the staff member involved (direct care staff N) named in the incident was not suspended but off work due to her normal schedule. Another document in the folder dated 04/15/2020 from the state insurance payor indicated the resident made an allegation of a facility staff member	S5028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5028	Continued From page 2	S5028		

(direct care staff N) spoke ruder and shoved her down on the toilet causing her to fall.

Record review revealed resident #9 admitted to the facility on 09/26/19 with diagnoses of heart attack, weakness, heart failure, diabetes mellitus 2, neuropathy, pain and vertigo (dizziness).

The admission functional capacity screen dated 09/26/2019 identified the resident with intact short-term memory but impaired long-term, memory recall and decision making. She required physical assistance with bathing, dressing and supervision with toileting, transfers and walking/mobility. She used a wheeled walker and was at risk for falling.

The negotiated service agreement dated 09/26/19 included services of staff assistance with bathing, dressing and needed supervision of 1 staff to toileting and assistance at times. She used a wheeled walker with ambulation by herself.

The nursing care plan dated 02/20/2020 directed staff to assist with toileting PRN (as needed), transfer assist of 1 with a gait belt and wheeled walker. Monitor closely and use additional staff PRN.

Review of the nurses' notes between 01/27/2020 and 04/09/2020 revealed an entry dated 02/09/2020 10:00 AM resident reported feeling weak, body aches, sore throat, runny nose and being cold. ... sent out by EMS (emergency management services) and noted later admitted to the hospital for diagnoses of UTI (urinary tract infection). On 02/11/2020 also diagnosed with a pleural effusion. She returned to the facility on 02/20/2020. An entry dated 02/21/2020 at 10:30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5028	Continued From page 3 AM which identified the resident as alert and oriented x 2 (but did not say which 2 of name, time, location) ... two person assist with cares for safety using a gait belt. On 02/25/2020 at 10:00 AM the 11pm-7am direct care staff report the resident transfers to the toilet with 1 assist, gait belt and wheeled walker. The next entry dated 03/13/2020 (without a time) read - direct care staff came to the desk and stated resident #9 wanted to talk to someone. Operator F went to the resident's room and talked with her. The record lacked any information about an allegation of mistreatment or any nursing evaluation for possible injuries related to a concern voiced. Records from the folder provided by operator F included a letter dated 04/14/2020 from the state insurance payor which briefly described an allegation made by the resident that a facility staff member spoke rudely and shoved her down on the toilet causing her to fall. The state insurance payor asked for additional information from the resident's record to review the allegation. An email sent by direct care staff L dated 04/21/2020 indicated on 03/12/2020 the resident used her call bell to ring for staff assistance to use the bathroom. When direct care staff L spoke with the resident about how her night was the resident responded direct care staff N had pushed her down onto the bedside commode. The resident said her buttocks and left arm was hurting. The resident said direct care staff N was very demeaning and hatefulness in her voice. Direct care staff L indicated she notified operator F of the incident. A letter within the folder signed by operator F dated 04/29/2020 to the state insurance payor identified operator F was made aware of the	S5028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5028	Continued From page 4	S5028		

resident's grievance on 03/13/2020, she went to talk with the resident. The resident verbalized she felt she was mistreated. The resident denied pain at the time of the visit. Operator F (a non-licensed nurse) wrote she assessed the resident to see if there were any visible signs of injury with none noted. ... The letter indicated operator F spoke with direct care staff N about the incident and the resident's concerns. Direct care staff N said she would be more careful and observant in the future.

A handwritten unnotarized signed statement from direct care staff N indicated on 03/12/2020 she assisted the resident to the bedside commode (BSC). The resident stood in front of the BSC pushing down her bottoms while staff N grabbed some disposable cleaning wipes. The resident started to fall back, so staff N grabbed her and sat her down on the BSC. Staff N wrote she said to the resident "what are you doing" and the resident jumped down her throat. Staff N told the resident not to be ugly towards her cause she wasn't with the resident. Staff N then told the resident she was going to get her co-worker and left the room.

None of the documents provided included the working schedule to show direct care staff N did not care for the resident during the facility's investigation. No formal evidence of an investigation was started until 04/14/2020 per the documents provided. The incident occurred on 03/12/2020 and the operator was informed of the incident on 03/13/2020.

Observation on 05/21/2020 at 1:30 PM revealed the resident sat in her recliner in her room watching TV. She remembered the incident but did not want to talk about it and felt the issues

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5028	Continued From page 5 was addressed. On 05/21/2020 at approximately 1:45 PM operator F confirmed she had provided all the documents about the incident she had. She confirmed she did not report the allegation to the state hotline number for abuse, neglect and exploitation. The undated facility's policy titled, Health Standard-Abuse, Neglect and Exploitation included a definition for abuse - meant any act or failure to act performed intentionally or recklessly which caused or is likely to cause harm to a resident, including: inflection of physical or mental injury, ... a threat or menacing conduct directed toward a resident which resulted in fear or emotional or mental distress to the resident ... Facility staff will ensure all allegations of abuse, neglect or exploitation are investigated and reported immediately to the administrator/on-call nurse and the state department on aging. The facility will have evidence that all alleged violations were thoroughly investigated and take measures to prevent further potential abuse, neglect and exploitation while the investigation is in progress. The operator failed to ensure staff reported an injury of unknown origin to the operator or on-call nurse and subsequent report to the state agency within 24 hours. The operator failed to meet the requirements of starting an investigation to rule out abuse or neglect and to have taken steps to protect residents while the investigation was in progress and ensuring each allegation had a thorough investigation which affected resident #9 who alleged rough/mistreatment by a staff member.	S5028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5028	Continued From page 6 - Record review revealed resident #8 an admission date of 07/15/19 with diagnoses of Alzheimer's, anxiety, depression, hypertension, coronary artery disease, congestive heart failure and peripheral vascular disease. The admission functional capacity screen (FCS) dated 07/15/19 indicated the resident had impaired cognition except for long-term memory. She needed physical assistance with dressing, bathing, transfers and supervision with toileting and walking. She used a wheeled walker and was at risk for falls. The negotiated service agreement (NSA) dated 07/15/2019 included staff assistance of 1 for dressing, ambulated with a wheeled walker and stand by assistance. An addendum to the NSA which is titled as "Care Plan Addendum" indicated on 10/05/19 a bed/chair alarm was added due to weakness and fall risk. Resident instructed to use call bell when needing to transfer or ambulate however, she wants to continue to call out for help. Uses her wheelchair for ambulation due to weakness and unsteady gait. On 11/18/19 the NSA was amended for PT/OT (physical therapy/occupation therapy) started for strengthening. The nursing care plan dated 07/25/19 directed staff to provided 1 person assist as needed, wheeled walker and stand by assist. The care plan did not include information related to fall risks, changes in her assistance needs as related to the use of a bed/chair alarm. Review of the nursing notes between 04/08/2020 and 05/14/2020 (last entry) revealed the resident had some medication changes for her anxiety. On 05/02/2020 at 10:40 AM resident seated in	S5028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5028	Continued From page 7	S5028		

recliner, hollered out for help, attempts to get out of chair unassisted insisting she needed to go home. Attempts to redirect were unsuccessful and medication administered as ordered for anxiety. On 05/04/2020 at 1:15 AM licensed nurse O wrote she received a call at home from direct care staff P regarding the resident getting out of bed. The resident was found out of bed with skin tears to her left arm. One directly on the elbow and the other about 2 inches lower than the elbow. The nurse cleansed the wound, approximated the skin and applied a dressing. No other injuries were noted. On 05/07/2020 at 3:30 PM licensed nurse B wrote he changed the dressing on the skin tears on the left arm. No mention of any other injuries. On 05/12/2020 (no time) licensed nurse B wrote a wound on the right elbow with increased redness, had a smell to it and was warm to the touch. ... he called the medical care provider and received an antibiotic order. No other injuries were noted. On 05/14/2020 (no time) licensed nurse B wrote right elbow washed with decreased redness, no edema or drainage with a 2 by 1.5 inch scabbed area.

A request to review the fall investigation for the above fall with injury was made on 05/21/2020 to licensed nurse B and C with no documentation provided for review.

Observation on 05/20/2020 at 3:48 PM revealed the resident seated in a recliner in the living room. Direct care staff disconnected a body alarm, applied a gait belt and assisted her to stand with a 4 wheeled walker. She bore weight on the left leg without facial pain or grimace and ambulated to the bathroom. Her left entire leg was bowed inward towards the other leg as she walked. On 05/21/2020 at approximately 2:30 PM observation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5028	Continued From page 8	S5028		

with licensed nurse C revealed the resident had a large purple/blue/green bruise on the left outer ankle approximate size of a half dollar. The area was slightly swollen and without heat per licensed nurse C. The lower portion of the anterior shin had a bruise which was just above the ankle and about the size of a quarter which was purple/blue. The left elbow had evidence of 2 healed/closed skin tears. The right elbow had a closed skin tear with a large area 3-4 inches across of a darker skin tone.

A notarized statement obtained on 05/21/2020 from direct care staff E indicated when she came to work (no date included) the resident had skin tears on both arms. She said direct care staff P said the resident had hurt it on the bathroom safety bard. The bruise on the resident's ankle she noticed on Friday 05/15/2020 while working the 3pm-11pm shift. She said the resident trys to get up out of the recliner or hangs her legs over the side. She did not remember if she told anyone about the bruise on the ankle.

Interview on 05/21/2020 at 2:40 PM with licensed nurse C revealed she was unaware of the bruising on the resident's ankle and did not know the cause.

Interview on 05/21/2020 at 3:00 PM with licensed nurse B revealed he was told about the fall on 05/04/2020 when he started on 05/07/2020 and given directions to change the dressing on the skin tears. He confirmed not being able to find any incident or fall investigations. He was not told about the resident ankle.

The undated facility's policy titled, Health Standard-Abuse, Neglect and Exploitation included a definition for abuse - meant any act or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5028	Continued From page 9	S5028		

failure to act performed intentionally or recklessly which caused or is likely to cause harm to a resident ... Facility staff will ensure all allegations of abuse, neglect or exploitation are investigated and reported immediately to the administrator/on-call nurse and the state department on aging. The facility will have evidence that all alleged violations were thoroughly investigated and take measures to prevent further potential abuse, neglect and exploitation while the investigation is in progress.

The operator failed to ensure staff reported this injury of unknown origin to the operator and subsequently reported to the department within 24 hours. The operator failed to meet the requirements for an investigation to rule out abuse or neglect and failed to have a thorough investigation for resident #8 with an injury of unknown origin.

- During an interview on 05/20/2020 at 3:38 PM with certified medication aide A revealed about a month ago the facility had 2 missing controlled substances.

On 05/21/2020 at 7:09 AM operator F reported an incident involving 2 missing narcotics. She could not name the narcotics or the resident(s) involved. She confirmed she did not have any written documentation of an investigation and had not reported the missing controlled substance to the state hotline number or law enforcement.

On 05/21/2020 at 8:35 AM operator F provided copies of drug testing requested on 4 different staff members done on 04/02/2020 and 04/03/2020. She reported the drug testing was requested because of the 2 missing controlled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5028	Continued From page 10 substances. On 05/21/2020 at 4:30 PM operator F confirmed she had no other documents related to the missing controlled substances. The undated facility's policy titled, Health Standard-Abuse, Neglect and Exploitation directed facility staff will ensure all allegations of abuse, neglect or exploitation are investigated and reported immediately to the administrator/on-call nurse and the state department on aging. The facility will have evidence that all alleged violations were thoroughly investigated and take measures to prevent further potential abuse, neglect and exploitation while the investigation is in progress. The operator failed to ensure each allegation of abuse, neglect or exploitation was reported to the department within 24 hours. The operator failed to meet the requirements for each allegation of starting an investigation, taking immediate actions to prevent further abuse, neglect or exploitation while the investigation was in progress and ensuring each allegation had a thorough investigation for missing controlled substances for 1 or more 1 unnamed residents.	S5028		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives	S5085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5085	Continued From page 11 assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201 (c)(2) The facility reported a census of 6 residents. The sample included 4 residents. Based on observation, interview and record review the operator failed to ensure designated staff conducted a functional screening for 1 of 4 sampled residents (#8)'s to determine her functional capacity following a hospital stay with a significant change in condition. Findings included: - Record review for resident #8 revealed an admission date of 07/15/2019 with diagnoses of Alzheimer's, anxiety, depression, hypertension, coronary artery disease, congestive heart failure and peripheral vascular disease. The admission functional capacity screen (FCS) dated 07/15/2019 and only screen in the resident chart identified the resident with impaired cognition other than long-term memory. She required physical assistance with bathing, dressing, transferring and needed supervision for toileting, walking/mobility. She used a wheeled walker and identified as a fall risk. Review of the nursing notes revealed on 02/05/2020 at 8:40 AM the resident reported hurting all over, feeling weak all over, cough with brownish gray phlegm, licensed nurse H called the medical care provider and the resident was transported by EMS (emergency management	S5085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5085	Continued From page 12 services). On 02/05/2020 at 1:00 PM licensed nurse H received a call from the hospital, the resident tested positive for influenza A and was admitted. On 02/13/2020 at 2:30 PM the resident returned to the facility. The note included the resident's diet order and medications but failed to include her functional abilities. On 2/13/2020 at 6:00 PM licensed nurse H wrote the resident was alert to name and place. She needed 1 person assist to the wheelchair and could bear weight. The notes on 02/15/2020, 02/16/2020 and 02/18/2020 all indicated the resident needed more assistance post hospital stay. Observation on 05/20/2020 at 3:48 PM revealed direct care staff M applied a gait belt loosely around the resident's waist. Staff M used the gait belt to provide moderate weight bearing assistance and an upward movement to assist the resident to a standing position from the recliner in the living room. Upon standing the resident took unsteady steps while staff M held onto the gait belt and guided the wheeled walker. Interview on 05/20/20 at 4:10 PM with certified medication aide A revealed the resident needed 1 person assist with all activities of daily living. Interview on 05/21/2020 at 4:30 PM operator F confirmed the resident had a change after the hospitalization and needed physical assist with all activities of daily living. The operator failed to ensure designated staff conducted a functional screening for this residents to determine her functional capacity following a hospital stay with a significant change in condition.	S5085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5155	Continued From page 13	S5155		
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus 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 26-42-204 (a) The facility reported a census of 6 residents. The sample included 4 residents. Based on observation, interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for 2 of 4 sample residents (#2 and #8) in accordance with the functional capacity screening and the negotiated service agreement related to falls. Findings included: - Record review for resident #2 revealed an admission date of 01/29/2020, with diagnosis of acute/chronic respiratory failure secondary to aspiration and pneumonia, dysphagia, dementia, hypertension, and end stage heart failure. The admission functional capacity screen dated 01/29/2020 identified the resident with impaired	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5155	Continued From page 14	S5155		

cognition all aspects and the resident needed physical assistance with dressing, toileting, transferring, and walking. The resident used are walker and wheelchair for mobility, was at risk for falling, had impaired vision, hearing and decision making.

The negotiated service agreement (NSA) dated 01/29/2020 included the following services provided by the facility: assistance to the toilet with 1 or 2 staff and use of a walker. Facility staff to assist with 1 staff for transfers and ambulation with a walker. The NSA lacked any information/services related to the resident's fall risk. Facility nursing services of skin assessments (did not specify a timeframe) and simple wound care.

The nursing care plan dated 01/29/2020 and without any changes, directed staff to assist the resident with all aspects of daily living. Staff to provide assist of 1 for transfers with a gait belt and walker. The resident is alert to name, can name spouse but disoriented to date or time with hallucinations at times. Staff to provide assistance of 1 to use the toilet and use of the walker. The care plan lacked any interventions to address and reduce the resident's fall risk.

Review of the nursing notes between 01/29/2020 and 05/20/2020 at 4:50 PM (last entry) revealed on 02/04/2020 at 7:10 AM direct care staff (not identified) found the resident on the floor on his knees facing the bed saying, "get me up". A total of 3 staff used a gait belt and assisted the resident back to bed. Licensed nurse H wrote the resident did not have red knees. The note lacked any information as to causal factors for the fall. The note lacked any interventions implemented by licensed nurse H to reduce the risk of future

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5155	Continued From page 15	S5155		

falls for the resident. An entry dated 02/05/2020 at 7:30 AM indicated an alarm sounded and when staff entered the room, he/she noted the resident slid to the floor from the bed. Two staff used a gait belt to assist the resident back to bed and licensed nurse H noted no injuries. The note indicated a bed alarm was in place and moved to the east side rail and shortened the string to allow for it to pull apart if the resident sat up thereby altering the staff. The note lacked any information into the causal factors for the fall or why the resident tried to get up. Both falls happened in the early morning hours. On 05/11/2020 at 11:40 AM licensed nurse B wrote staff found the resident lying on the floor next to the bed. The bed pressure pad alarm was in use at the time according to the staff on duty. Licensed nurse B noted no injuries, change in level of consciousness or pain and 2 staff assisted the resident back to bed. The bed alarm was checked and put into use. The resident had experienced incontinence of bowel movement and stated that was why he needed help.

Review of the facility's fall investigation dated 05/11/2020 at 10:40 AM revealed prior to being found on the floor the resident was in bed sleeping. The description of the incident included - staff heard the resident call out from the room and staff found the resident lying on the floor next to the bed. The description did not indicate if before mentioned alarm was in place and functioning. The investigation did not address the time the resident was last seen, last toileted or cares provided to determine causal factors of the fall and reason the resident attempted to get out of bed. The investigation lacked any additional intervention put into place to reduce the resident's risk for further falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5155	Continued From page 16 Interview on 05/20/2020 at 4:30 PM with licensed nurse B revealed the only fall/incident investigation he could find was the one he completed for the fall on 05/11/2020. He confirmed the investigation failed to indicate whether the alarm was in place and functioning or causal factors of the fall related to toileting needs or other care needs. He confirmed that neither the investigation nor care plan identified any intervention as a result of this fall to reduce the resident's risk of further falls. The facility's undated Falls policy directed staff to notify the nurse, the nurse will do an assessment and fill out a fall intervention form. Pages included with the policy included a room check after fall for various items or equipment placement, function and a place for comments with a nurse signature. A page titled, follow up report to administrative investigation to be completed within 1 week of incident included the date/time of incident, type of incident/accident, intervention in place and whether they were successful or other actions needed. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for this resident in accordance with the functional capacity screening and the negotiated service agreement related to repeated falls. - Record review for resident #8 revealed an admission date of 07/15/2019 with diagnoses of Alzheimer's, anxiety, depression, hypertension, coronary artery disease, congestive heart failure and peripheral vascular disease. The admission functional capacity screen (FCS) dated 07/15/2019 identified the resident with	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5155	Continued From page 17	S5155		

impaired cognition other than long-term memory. She required physical assistance with bathing, dressing, transferring and needed supervision for toileting, walking/mobility. She used a wheeled walker and identified as a fall risk.

The negotiated service agreement (NSA) dated 07/15/2019 included staff assistance of 1 for dressing, ambulated with a wheeled walker and stand by assistance. An addendum to the NSA which is titled as "Care Plan Addendum" indicated on 10/05/19 a bed/chair alarm was added due to weakness and fall risk. Resident instructed to use call bell when needing to transfer or ambulate however, she wants to continue to call out for help. Used her wheelchair for ambulation due to weakness and unsteady gait. On 11/18/19 the NSA was amended for PT/OT (physical therapy/occupation therapy) started for strengthening.

The nursing care plan dated 07/25/19 directed staff to provided 1 person assist as needed, wheeled walker and stand by assist. The care plan did not include information related to fall risks, changes in her assistance needs as related to the use of a bed/chair alarm and after a hospital stay with a change in her abilities.

Review of the nursing notes between 04/08/2020 and 05/14/2020 (last entry) revealed the resident had some medication changes for her anxiety. An entry dated 05/02/2020 at 10:40 AM indicated the resident sat in a recliner, hollered out for help, attempted to get out of the recliner unassisted and insisting she needed to go home. Attempts to redirect were unsuccessful and medication administered as ordered for anxiety. On 05/04/2020 at 1:15 AM licensed nurse O wrote she received a call at home from direct care staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5155	Continued From page 18 P regarding the resident getting out of bed. The resident was found out of bed with skin tears to her left arm. One directly on the elbow and the other about 2 inches lower than the elbow. The nurse cleansed the wound, approximated the skin and applied a dressing. No other injuries were noted. The note lacked any information as to causal factors for the fall, whether the planned bed/chair alarm was in place and functioning or what the resident wanted to do at the time of the fall. The note lacked any additional interventions put into place to reduce the resident's risk for further falls. A request to review the fall investigation for the above fall with injury was made on 05/21/2020 to licensed nurse B and C with no documentation provided for review. Observation on 05/20/2020 at 3:48 PM revealed the resident seated in a recliner in the living room. Direct care staff disconnected a body alarm, applied a gait belt and assisted her to stand with a 4 wheeled walker. She bore weight on the left leg without facial pain or grimace and ambulated to the bathroom. Her left entire leg was bowed inward towards the other leg as she walked. On 05/21/2020 at approximately 2:30 PM observation with licensed nurse C revealed the resident had a large purple/blue/green bruise on the left outer ankle approximate size of a half dollar. The area was slightly swollen and without heat per licensed nurse C. The lower portion of the anterior shin had a bruise which was just above the ankle and about the size of a quarter which was purple/blue. The left elbow had evidence of 2 healed/closed skin tears. The right elbow had a closed skin tear with a large area 3-4 inches across of a darker skin tone.	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5155	Continued From page 19 During an interview on 05/21/2020 at 2:27 PM with direct care staff E she said the resident had fallen in the last couple of weeks. She reported the resident had skin tears on her arms which occurred on the night shift and banging on the safety bars for the toilet. She noticed the bruise on the ankle Friday 05/15/2020, did not know the cause and could not remember is she told the nurse about it. Interview on 05/21/2020 at 4:30 PM licensed nurse B and C confirmed the records lacked any evidence of a facility investigation for the fall on 05/04/2020 or the injury of unknown origin on the left ankle. Both confirmed the care plan did not include information related to the resident's fall risk and no additional interventions were implemented after the fall on 05/04/2020. The facility's undated Falls policy directed staff to notify the nurse, the nurse will do an assessment and fill out a fall intervention form. Pages included with the policy included a room check after fall for various items or equipment placement, function and a place for comments with a nurse signature. A page titled, follow up report to administrative investigation to be completed within 1 week of incident included the date/time of incident, type of incident/accident, intervention in place and whether they were successful or other actions needed. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for this resident in accordance with the functional capacity screening and the negotiated service agreement related to falls and injuries.	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5185	Continued From page 20	S5185		
S5185 SS=D	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (c) The facility reported a census of 6 residents. The sample included 4 residents. Based on observation, interview and record review the operator failed to ensure staff provided the pureed diet for 1 of 4 sampled residents (#2) in accordance with negotiated service agreement and instructions from medical provider. Findings included: - Record review for resident #2 revealed an admission date of 01/29/2020 with diagnoses of acute & chronic respiratory failure secondary to aspirations, pneumonia, dysphagia, dementia, hypertension, and end stage heart failure.	S5185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5185	Continued From page 21	S5185		

The admission functional capacity screening dated 01/29/2020 identified the resident with impaired cognitive impairment and required supervision with eating.

The negotiated service agreement dated 01/29/2020 (without amendment) included the following services provided by the facility: 3 meals daily, PRN (as needed) snacks, pureed diet, thickened liquids, and he could feed himself.

The nursing care plan dated 01/29/2020 directed staff to provide the resident a pureed diet with thickened liquid and indicated "family will give regular liquids".

Review of the nursing notes' between 01/29/2020 and 05/20/2020 revealed an entry dated 05/08/2020 (no time written) licensed nurse B wrote a staff member reported the resident was coughing and possibly chocked at lunch or some part of it. Resident denied choking on lunch. He had a non-productive cough intermittently through the afternoon. Licensed nurse B called the resident's family member about his condition. The family member said the resident had a swallow study in January and he refused the diet changes.

Record review revealed a hospital inter-agency transfer record with a medical care provider's order signed 01/28/2020 for a pureed diet with pudding thick liquids.

On 05/21/2020 at approximately 2:35 PM observation revealed direct care staff K gave the resident 2 Oreo cookies in their original form. The resident placed a cookie in his mouth independently and while eating he started coughing. The resident sat in a recliner in the living room with his body downward in the recliner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5185	Continued From page 22 and the feet up in a reclined position. Licensed nurse C also present in the room responded to the resident's choking. Interview on 05/21/2020 at 2:38 PM with licensed nurse C confirmed the resident had a diet order for pureed foods and thickened liquids. She said the family brings in these food items for the resident. Interview on 05/21/2020 at 2:45 PM with licensed nurse B confirmed the resident had a medical care provider's order for a pureed diet with thickened liquids but the resident did not want to follow the medical care provider's orders. He confirmed the record lacked information regarding the resident's refusal for recommended services. The operator failed to ensure staff provided the prescribed pureed diet for this resident in accordance with negotiated service agreement.	S5185		
S5316 SS=E	26-42-205 (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 home 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	S5316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5316	Continued From page 23 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. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (i)(1)(A)(B) The facility reported a census of 6 residents. The sample included 4 residents. Based on observation, interview and record review the operator failed to ensure proper accountability and dispostion of medications managed by the facility in sufficient detail for an accurate reconciliation regarding a controlled substance for resident #1, medications held in storage which were discontinued, expired or discharged residents for an extended period of time (#2, #3, #4, #6, #7, #8, #9, #10, #11, #12 and #13). The operator also failed to ensure the destruction of controlled substances by 2 licensed nurses or a licensed nurse and a licensed pharmacist for resident #2, #8, #3, and #7. Findings included: - The resident roster provided by licensed nurse C on 05/20/2020 indicated the facility managed medications for all 6 residents.	S5316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5316	Continued From page 24 On 05/20/2020 at 2:36 PM during the medication storage observation with licensed nurse C she reported finding discrepancies within the controlled substance accounting record. Observation and reconciliation to resident #1's individual controlled substance record revealed the resident had only 1 bottle of Morphine Sulfate Solution in the locked controlled substance drawer of the medication cart. There were 2 sheets for Morphine Sulfate for the resident. No bottle was found to go with the sheet which had a last entry date of 04/08/2020. The 04/08/2020 at 7:00 AM entry indicated the bottle contained 7.0 milliliters (ml) as noted by certified medication aide (CMA) E and G with a notation of correct count. The previous documented dose occurred on 04/07/2020 at 6:30 PM by CMA A of 0.25 ml with an ending amount of 8.75 ml. Licensed nurse C confirmed she could not locate a bottle of morphine to go with the individual record ending on 04/08/2020. Interview on 05/20/2020 at 3:38 PM CMA A said as a CMA she does not usually give Morphine to the resident but on 04/07/2020 the resident was having a lot of pain so she called the nurse and got permission to give the resident some Morhpine. When she went to draw out the 0.25 ml dose she had to remove the stopper to get down in the bottle enough to draw it up. She replaced the stopper and put the bottle back in the locked drawer of the medication cart and signed the dose out in the book. She had no knowledge of what happened to the bottle. She said on the morning of 04/08/2020 when she reported for duty CMA she was told that 2 CMAs corrected the amount on the count sheet. Interview on 05/21/2020 at 2:27 PM with CMA E	S5316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5316	Continued From page 25	S5316		

revealed she knew of a time in the past year when some liquid morphine was spilled in the medication cart but could not narrow down a timeframe. She was not involved in it. She did not know what happened to the bottle of morphine for resident #1. She said the count and compare the controlled substances at the change of every shift and if the count is off will call the nurse. She did not remember if the nurse was called about the correcting of the count she signed on 04/08/2020.

The facility's undated policy tiltled Health Standard-Narcotics directed staff to perform a narcotic (controlled substance) count at the beginning and ending of every shift if both staff are medication aides. Upon completion of the count both medication aides will sign the narcotic count sheet. The nurse will monitor narcotics on a regular basis.

Interview on 05/21/2020 at 4:30 PM with operator F revealed she had no knowledge of the missing morphine. She confirmed and expectation for licensed nurses and CMAs to keep accurate records for all controlled substances and when discrepancies in the count occurred the nurse should be called to get directions on how to proceed.

The operator failed to ensure proper accountability and disposition of medications managed by the facility in sufficient detail for an accurate reconciliation regarding a controlled substance for resident #1

- The resident roster provided by licensed nurse C on 05/20/2020 indicated the facility managed medications for all 6 residents.

On 05/20/2020 at 2:36 PM during the medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5316	Continued From page 26	S5316		

storage observation with licensed nurse C she reported on her first day of employment she noted the medication room to have an excessive amount of medications stacked on the mini-fridge and top surface of a washer/dryer stored in the medication room. She reported organizing the medications by resident and writing the return/destruction sheets to send the medications back to the pharmacy. She confirmed some of the medications were for residents who passed away several months ago. She said medications need to be returned to the pharmacy as soon as possible for credit or destroyed. Observation revealed the following medications stored in the medication room and not returned to the pharmacy for credit at the time of discharge:
Resident #3 passed away on 03/25/2015 with a remaining box of Aquacel Rope wound dressing which had a pharmacy label dispensing date of 03/06/2015.
Resident #10 passed away on 04/02/2019 with a 1/2 full bottle of Miralax which had a pharmacy label dispensing of 05/22/2017 and an opened bottle of Fluticasone (allergy nose spray).
Resident #12 passed away on 09/17/2019 with unopened bottle of Tussin DM (dextromethorphan a cough suppressant).
Resident #6 passed away on 10/27/2019 with remaining 2 medication cards of Tylenol (acetaminophen) and different directions with dispensing dates of 08/26/2019 and 09/04/2019.
Resident #7 passed away on 04/25/2020 with 8 cards of various medications and dispensing dates between (12/23/19 - 4-22-20). She also had over the counter open bottle almost full of Calcium 600 milligrams and a 1/2 full bottle of Robitussin DM cough syrup.
Resident #4 discharged to another facility on 11/24/2019 with 8 cards of various medications dispensed in the month of October 2019 and a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5316	Continued From page 27	S5316		

bottle of nitrostat with approximately 15 tablets. Resident #3 discharged to another facility on 03/28/2020 with 27 cards of various medications dispensed between (01/14/2020 - 02/26/2020.

The medication room also had an excessive amount of medications cards for current residents with various amounts in the cards which licensed nurse C said were medications which were discontinued, changed or they just had extras but did not know the reason as follows:
Resident #2 had 4 cards of various medications with 2-6 tablets remaining in the cards and dispense dates between 01/30/2020--2/21/2020.
Resident #8 had 19 cards of various medications with 1-22 tablets remaining in the cards. As an example Risperadol filled on 02/21/2020 for 3 times a day all 3 cards had 3 of 31 tablets remaining.
Resident #9 had 16 cards of various medications with 3 -22 tablets remaining in the cards.
Resident #11 had 2 cards of amlodipine (a blood pressure medication) 1 card with 2 of 31 tablets remaining dispensed on 12/26/19 and 1 card with 16 of 29 tablets remaining in the card dispensed on 01/25/2020.
Resident #13 had 6 cards of various medications with 1-3 tablets remaining in the cards.

A notarized statement obtained on 05/20/2020 at 3:38 PM with certified medication aide (CMA) A revealed the extra medications in the medication room were medications which were discontinued, extras from the month or for expired residents. She said CMAs in the past have written up the medications on the form to send back but the nurse has also. She said there was no certain person assigned to do this task.

Interview on 05/20/2020 at 3:00 PM with licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5316	Continued From page 28	S5316		

nurse C confirmed medications should be returned to the pharmacy for credit as soon as possible or destroyed.

Interview on 05/20/2020 at 4:28 PM with licensed nurse B revealed he attempted to straighten up the medication storage room on 05/12/2020 where he observed all the above medications stacked on the top of the mini-fridge and washer/dryer. He asked staff about them and was told the medications were changed or something so he did not attempt to do anything with them while he went through the resident's charts looking for current up to date orders for medications.

Interview on 05/21/2020 at 4:30 PM with operator F confirmed the discontinued, extras or medications for discharged residents needed to be processed and returned to the pharmacy for credit as soon as possible.

The operator failed to ensure proper accountability and disposition of medications managed by the facility in sufficient detail for an accurate reconciliation regarding medications held in storage which were discontinued, expired or from discharged residents for an extended period of time (#2, #3, #4, #6, #7, #8, #9, #10, #11, #12 and #13).

- The resident roster provided by licensed nurse C on 05/20/2020 indicated the facility managed medications for all 6 residents.

Review of the notebook for the individual controlled substance records for resident revealed the following:
Resident #7 passed away on 04/25/2020 her individual controlled substance records included 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S5316	Continued From page 29	S5316		

medications marked as destroyed on 05/07/2020 by licensed nurse H and certified medication aide (CMA) J and not by 2 nurses or a nurse and a pharmacist as required.
Resident #3 discharged to another facility on 03/25/2020 and her individual controlled substance records included 4 medications marked as destroyed on 03/30/2020 by licensed nurse H and CMA A.
Resident #8 had 3 individual controlled substance sheets (1 with 21 tablets and 2 with 30 tablets each) of Lorazepam 0.5 milligrams every 6 hours PRN (as needed). None of the sheets indicated what happened to the medications but were signed by licensed nurse H and CMA E.
Resident #2 had an individual controlled substance sheet for Tramadol HCL 50 milligrams 1 by mouth 3 times a day. On 04/06/2020 CMA G wrote dropped and destroyed and no indication of the destruction by 2 nurse or a licensed nurse and a pharmacist.

Interview on 05/21/2020 at 4:30 PM with operator F confirmed the facility's policy and the regulation required all controlled substances to be destroyed by 2 licensed nurses or a licensed nurse and a licensed pharmacist.

The facility's undated policy titled Medication Disposition Records (Regular or Controlled drugs) (Discharge/Destruction) directed staff - Controlled substances were to be destroyed by 2 nurses.

The operator failed to ensure 2 licensed nurses or a licensed nurse and a licensed pharmacist destroyed controlled substances for residents #2, #3, #7 and #8.