STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087069	A. BUILDING: _____ B. WING _____	C 09/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT PARK ASSISTED LIVING AND MEMORY CAF	10600 E 13TH STREET NORTH WICHITA, KS 67206

(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 the resurvey and complaints #155400 and #152607 for the above named facility conducted on 09/09/2020, 09/10/2020, 09/14/2020, 09/15/2020 and 09/16/2020.	S 000		
S3026 SS=D	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f) (1) (B) The facility reported a census of 77 residents. The sample included 6 residents. Based on observation, interview and record review the administrator/operator failed to ensure staff provided adequate supervision as planned for 1 of 6 sampled residents (#239) which allowed the resident to be absent from the facility without staff knowledge on 08/25/2020. Findings included: - Record review revealed resident #239 admitted to the facility on 08/07/2020 with diagnoses of Lewy body dementia, delusional	S3026		

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

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REGENT PARK ASSISTED LIVING AND MEMORY CAR	10600 E 13TH STREET NORTH WICHITA, KS 67206

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S3026	Continued From page 1	S3026		

disorder, anxiety disorder, major depressive disorder, selfcare deficit, adjustment disorder, pain and a history of kidney stones.

The admission functional capacity screen (FCS) dated 08/06/2020 identified the resident with impaired cognition in all aspects. He required physical assist in bathing, supervision with dressing and toileting and walked/mobile independently. On the section for current or recent problems/risks licensed nurse L marked him with impaired vision and decision making but failed to mark wandering and socially/disruptive behavior.

The negotiated services agreement/healthcare service plan (NSA/HCS) dated 08/07/2020, indicated the resident had behaviors of frustration, frequent pacing/aimless wandering, rejection of cares. The NSA/HCS directed staff to report any physical aggression towards staff to nursing. He is oriented to self, family and partner, may require reorientation at times to surroundings, and staff directed to provide reassurance and validation if/when the resident displayed exit seeking, pacing, or wandering behaviors. Resident medications included a psychotropic medication to manage dementia with behaviors. Staff should allow the resident to wander the unit while ensuring his safety. Amendment to NSA/HCS on 08/25/2020 included the following interventions: "gate lock time [changed] to 1 second, supervised courtyard visits only, do not take trash while resident in courtyard, notify nurse of increasing or changed behaviors". (See below for observation on 09/10/2020 of the gate door not latching)

Review of the elopement risk assessment dated

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S3026	Continued From page 2 08/07/2020 revealed the resident scored a 6-low risk for elopement. Licensed nurse L marked resident as occasionally disoriented to time and place, re-orients easily, and has no other behaviors associated with memory impairment. This did not match the NSA/HCS plan. Review of the electronic record charting notes revealed on 08/07/2020 the resident was agitated, yelling and aggressively pushing and moving his walker. On 08/21/2020 the resident had increased delirium and hallucinations with no specifics indicated. Nursing note dated 08/26/2020 indicated the resident was observed by staff on 08/25/2020 walking in the courtyard; staff took trash out the courtyard gate to a dumpster and when staff turned around from the dumpster to go back inside, the resident was sitting on the curb outside of the gate. Staff called the resident's name and he walked to the gate with staff and ambulated inside the building. (this did not match the description of the event as told in the interview on 09/10/2020) Review of the facility's investigation of the event revealed an undated signed statement from certification medication aide (CMA) C about events of 08/25/2020 which indicated she was told by the CMA on duty it was ok for the resident to be in the courtyard. She indicated she did not let the resident see the code (did not specify what code on what door or gate) as she took the trash out. She indicated she made sure the gate was closed once she went through it. When she turned around to come back inside, she observed the resident sitting on the curb (did not specify which curb, how far away from the building or how far she was away from the resident). She stated she called the resident by name and he	S3026		

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S3026	Continued From page 3	S3026		

followed her back inside. Statement states a bolt was missing and maintenance fixed the gate after the incident. She wrote the gate apparently had a bolt missing and maintenance fixed the gate today after the incident.

An undated signed statement by CMA H indicated her co-worker (CMA C) told her she was going to take the trash out. CMA H continued with passing medications. She looked around to see where resident #239 was and he was not outside (the dining room area where the medication cart is located had a large picture window and most of the courtyard was visible). She went to see if the resident was in his room and he was not there either. She was on her way back to the courtyard when her co-worker (CMA C) called on the phone and told CMA H resident #239 got out. CMA H indicated CMA C told her she noticed the resident when she came back from taking out the trash, sitting over on the curb, down towards the other facility and she needed CMA H to come out and unlock the gate.

Interview on 09/10/2020 at 10:38 AM with life enrichment employee F revealed she had gone on lunch break during the time of the incident.

Interview on 09/10/2020 at 10:50 AM with CMA C revealed staff usually checked the lock, and didn't this time, and the bolt from the center of the magnet was missing and she reported to maintenance after the incident. She went to the dumpster approximately 50 feet and when she turned back around to go back to the facility she observed the resident sitting on the curb, she stated she yelled his name and assisted him back to the unit with no problems.

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S3026	Continued From page 4 Interview on 09/10/2020 at 11:14 AM with CMA H revealed staff had disengaged the alarm to the door from the building to the courtyard so residents could go outside in the nice weather. She stated she resumed duties of passing medications and thought other staff had brought the residents back inside. Observation of the courtyard on 09/10/2020 at 10:40 AM with Life enrichment staff F revealed the courtyard gate was locked. She put the code in with several failed attempts to open. Once opened the gate closed but did not engage the lock, she stated, "you had to pull up on the gate door to engage the lock". Outside of the courtyard gate the sidewalk made an L shaped turn to the right of approximately 3 feet to the curb and then onto an asphalt drive towards the back of the facility. Approximately 250 feet away from this area sat the dumpsters for the trash. Across the asphalt driveway about 50-75 feet was another curb which lead to the long-term care facility. Interview on 09/10/2020 at 11:01AM with maintenance employee G he stated the courtyard gate will close on its own and the lock would engage after 1 second. He reported no bolts were missing and he merely needed to tighten the bolts. He reported checking the function of the doors, gates and alarms on a weekly basis. Further observation on 09/10/2020 at 11:10 revealed once the code was entered on the keypad the gate lock disengaged, the gate swung open when pushed and when you let go of the gate it swung back, but failed to close completely or engage the locking mechanism.	S3026		

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S3026	Continued From page 5 Interview and observation on 09/10/2020 at 11:13 AM with administrator/operator O confirmed the gate failed to close and lock on its own. Observation on 09/10/2020 at 11:14 AM revealed the resident attempted to go out the door to the courtyard and set the door alarm off. Administrator/operator O attempted to redirect the resident several times before she was able to get him to leave the doorway. The facility's policy titled Resident Abuse, Neglect and Exploitation dated 07/03/2019 included a definition for "Neglect" to mean a failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. The administrator/operator failed to ensure staff provided adequate supervision as planned for resident #239 which allowed the resident to be absent from the facility without staff knowledge on 08/25/2020.	S3026		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201 (d)	S3082		

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S3082	Continued From page 6	S3082		

The facility reported a census of 77 residents. The sample included 6 residents. Based on observation, interview and record review the administrator failed to ensure 2 of 6 sampled residents functional capacity screening (#239 and #262) accurately reflected the resident's functional capacity at the time of screening regarding wandering behavior, socially inappropriate behavior and toileting.

Findings included:

- Record review revealed resident #239 admitted to the facility on 08/07/2020 with diagnoses of Lewy body dementia, delusional disorder, anxiety disorder, major depressive disorder, selfcare deficit, adjustment disorder, pain and a history of kidney stones.

The admission functional capacity screen (FCS) dated 08/06/2020 identified the resident with impaired cognition in all aspects. He required physical assist in bathing, supervision with dressing and toileting and could walk/mobility independently. The section for current or recent problems/risks licensed nurse L marked him with impaired vision and decision making but failed to mark wandering and socially/disruptive behavior.
The negotiated services agreement/healthcare service plan (NSA/HCS) indicated the resident had behaviors of frustration, frequent pacing/aimless wandering, rejection of cares. The NSA/HCS directed staff to report any physical aggression towards staff to nursing.

Review of the electronic record charting notes revealed on 08/07/2020 the resident was agitated, yelling and aggressively pushing and

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S3082	Continued From page 7 moving his walker. On 08/21/2020 the resident had increased delirium and hallucinations with no specifics indicated. Observation on 09/10/2020 at 11:14 AM revealed the resident attempted to go out the door to the courtyard and set the door alarm off. Administrator O attempted to redirect the resident several times before she was able to get him to leave the doorway. On 09/14/2020 observation revealed the resident wandered by the kitchen area, with no purpose, as he touched items and stood too close when talking to others (invading their personal space). Interview on 09/10/2020 at 10:20 AM licensed nurse Q confirmed the NSA/HCS and nursing notes indicated the resident had wandering and inappropriate behavior which was not reflected in the 08/06/2020 FCS. The administrator failed to ensure this resident's functional capacity screening accurately reflected the resident's functional capacity at the time of screening for wandering and socially inappropriate behavior. The administrator failed to ensure this resident's functional capacity screening accurately reflected the resident's functional capacity at the time of screening regarding wandering behavior and socially inappropriate behavior. - Record review for resident #262 revealed an admission date of 10/18/2017 with diagnoses of dementia, gastroesophageal reflux disease, osteopenia, urgency incontinence, hypertension and transient ischemic attack.	S3082		

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S3082	Continued From page 8 The annual functional capacity screen (FCS) dated 06/29/2020 identified the resident with impaired cognition in all aspects. She needed physical assistance with bathing, dressing and toileting. The negotiated service agreement/healthcare service plan (NSA/HCS) dated 06/29/2020 included services of 1 staff to provide physical assistance for bathing and dressing. The NSA/HCS plan for toileting did not include any physical assistance and directed staff to provide verbal cueing to manage incontinence and she wore protective garments. On 09/10/2020 at 10:38 AM observation revealed the resident stood in the doorway of her room trying to buckle her belt around her waist. She walked without aid of any assistive device. Interview on 09/14/2020 at 10:30AM with certified medication aide E confirmed the resident was independent with toileting. Interview on 09/15/2020 at 9:45 AM licensed nurse L confirmed the FCS was not accurate for toileting needs. The operator failed to ensure this resident's functional capacity screening accurately reflected the resident's functional capacity regarding level of self-performance with toileting at time of screening.	S3082		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator	S3101		

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S3101	Continued From page 9 shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (h) The facility reported a census of 77 residents. The sample included 6 residents. Based on record review and interview the administrator/operator failed to ensure each individual involved in the development of the negotiated service agreement signed the agreement for 3 of 6 sampled residents (#489, #239 and #722). Findings included: - Record review for resident #489 revealed an admission date of 03/29/2019 with diagnoses of dementia, atrial fibrillation, cerebral vascular accident, hypertension, mood disturbances and insomnia The annual functional capacity screen dated 05/29/2020 identified the resident with cognitive impairment in all aspects an ability to manage his medication physical assistance needed for treatments an independent with all other activities of daily living. the functional capacity screen did not identify the residents wandering or socially inappropriate behavior. The negotiated service agreement dated 05/29/2020 included services of reminders and prompts to shower, verbal cues to evacuate or	S3101		

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S3101	Continued From page 10	S3101		

participate in safety drills. The resident resided in a memory care locked unit due to behaviors of packing belongings and statements about leaving. The resident required direction or reminders to participate in activities, was alert and oriented to self, family and his surroundings, but disoriented to time and place. Staff need to reorient the resident. The resident required the implementation of a specialized service plan to prevent or manage unacceptable behavior which does not require 1:1 assistance. He had a history of putting objects into his toilet, packed his bags and goes to the exits. He had times of noted agitation and staff instructed to reproach at a later time and provide redirection. The resident's medications would be administered by certified medication aides or licensed nurses. The only signature on the NSA/HCS plan was administrator O and not signed by a licensed nurse which was indicated with the need for health care services or by the resident's responsible party.

Interview with licensed nurse L on 09/14/2020 at 3:39 PM confirmed the NSA/HCS plan lacked a signature by a licensed nurse and the residents responsible party to indicate they participated in the development of the plan.

The administrator/operator failed to ensure each individual involved in the development of the negotiated service agreement signed the agreement for this resident.

- Record review revealed resident #239 admitted to the facility on 08/07/2020 with diagnoses of Lewy body dementia, delusional disorder, anxiety disorder, major depressive

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S3101	Continued From page 11	S3101		

disorder, selfcare deficit, adjustment disorder, pain and a history of kidney stones.

The admission functional capacity screen (FCS) dated 08/06/2020 identified the resident with impaired cognition in all aspects. He required physical assist in bathing, supervision with dressing and toileting and could walk/mobility independently. The section for current or recent problems/risks licensed nurse L marked him with impaired vision and decision making but failed to mark wandering and socially/disruptive behavior.

The negotiated services agreement/healthcare service plan (NSA/HCS) indicated the resident had behaviors of frustration, frequent pacing/aimless wandering, rejection of cares. The NSA/HCS directed staff to report any physical aggression towards staff to nursing. The NSA/HCS plan was revised on 08/25/2020 regarding changes to the courtyard gate lock and supervision when in the courtyard following an elopement on 08/25/2020. The revision lacked signature by the nurse or the resident's responsible party for the changes.

Interview on 09/10/2020 at 10:20 AM licensed nurse Q revealed an expectation for the person making the changes to sign and to make a note if the responsible party was consulted by phone, email or regular mail for the changes until such time the person could sign the document.

The administrator/operator failed to ensure each individual involved in the development of the negotiated service agreement signed the agreement for this resident.

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S3186	Continued From page 12	S3186		
S3186 SS=E	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (b) The facility reported a census of 79 residents. The sampled included 6 residents. Based on record review and interview the administrator/operator failed to ensure the negotiated service agreement identified who was responsible for the administration and management of selected medications when the resident chooses to self-administer some of their medications and for the facility to manage selected medications for 1 of 6 sampled residents (#311). The negotiated service agreement for 2 of 6 sampled residents (#239 and #262) failed to accurately reflect who administered and managed the resident's medications. Findings included:	S3186		

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S3186	Continued From page 13 - Record review for resident #311 revealed an admission date of 06/23/2020 with diagnoses of cancer, congestive heart failure, coronary artery disease, hypertension and hyponatremia. The admission functional capacity screen (FCS) dated 06/22/2020 identified the resident with intact cognition and needed physical assist with medication and treatment management. Another FCS dated 07/27/2020 identified the with intact cognition and only needed supervision with medication and treatment management. The self-administration of medication review form conducted by licensor nurse L on 06/30/2020 identified the resident as fully capable to self-administer his medications other than PRN (as needed) medications, eye drops, eye ointments, topical ointments and creams, topical patches, ear drops rectal suppositories, inhalant medication or subcutaneous injections. The negotiated service agreement (NSA) dated 07/27/2020 under the section marked health supplies: facility staff to set up and manage medication administration. The resident had a cancer medication which he received directly from the manufacturer. Under the Wellness monitoring and treatments, the NSA directed staff the resident took some of his medications crushed due to a fluid restriction and he was safe to self-administer a portion of his medications. The NSA failed to identify which of those medications he would self-manage. Under the section titled medication, facility staff to set up, administer and monitor ingestion of medications. Staff to reorder medications as needed and the resident had a cancer drug which came by mail and family would deliver. Under medication	S3186		

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management, the NSA directed staff the resident's medications would be administered by certified medication aides or licensed nurses.

Review of the electronic record charting notes revealed an entry dated 06/23/2020 at 5:01 PM which indicated the resident arrived to the facility. The entry stated he was able to take his own vitamins and a request to self-administer was faxed to the medical care provider. An entry dated 07/01/2020 at 1:40 PM indicated the resident did not want his medications crushed, at least not all of them, he crushed them prior because of his fluid restriction and the amount of fluids needed to take them. He reported a desire to keep his cancer medication in his room to take when he eats breakfast. A request for self-administration was sent to the medical care provider. Self-administration of medication assessment completed with the resident capable. An entry dated 08/17/2020 at 10:30 AM indicated the resident requested his afternoon dose of Lasix be given after dinner.

Review of the September 2020 medication administration record (MAR) revealed the following medications recorded as not given by the facility:
aspirin enteric coated 81 milligrams (mg) every day 7:00 AM
calcium carbonate 10 grains every day at 7:00 AM
Caltrate bone health twice daily 7:00 AM and 7:00 PM
Co Q10 capsules every day at 7:00 AM
manganese 250 mg every day at 7:00 AM
multivitamin tabs every day at 7:00 AM
NUBEQA 300 mg twice a day 7:00 AM and 7:00 PM

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omega-3 cap at 7 AM
turmeric twice daily for arthritis at 7:00 AM and 7:00 PM
VISIVITE a Reds 2 plus gold one pill twice daily 7:00 AM and 7:00 PM
Vitamin C tabs 7:00 AM

The September 2020 MAR indicated facility staff administered the following medications per staff initials:
clopidogrel bisulfate 75 mgs daily
Entresto F/C 24 mg-26 mg twice daily
furosemide 80 mg twice daily
potassium chloride 20 milliequivalents twice daily
spironolactone 25 mg daily

Interview on 09/14/2020 at 11:20 AM with licensed nurse L confirmed the resident self-administered some of his medications and facility staff administered some. She confirmed the NSA failed to identify the selected medications which the resident would self-administer and which medications the facility would manage.

The facility's policy titled Self-Administration of Medications dated 07/01/2012 directed staff a resident who self-administers medications may select specific medication to be administered by a licensed nurse employed by the facility, a home health agency or hospice or by a medication aide/assistant employed by the facility. The Negotiated Service Agreement should reflect this service and identify who will be responsible for management of the selected medications.

The administrator/operator failed to ensure the negotiated service agreement identified who was

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responsible for the administration and management of selected medications when the resident chooses to self-administer some of their medications and for the facility to manage selected medications for this resident.

- Record review for resident #239 revealed an admission date now the 08/07/2020 with diagnoses of Lewy body dementia, delusional disorder, anxiety disorder, major depressive disorder, selfcare deficit, adjustment disorder and pain.

The admission functional capacity screen dated 08/06/2020 identified the resident with cognitive impairment in all aspects and he was unable to manage his medications and treatments.

The negotiated service agreement/health care services plan (NSA/HCS) dated 08/07/2020 under safety it read, resident with diagnosis of Lewy body dementia and required supervision daily due to mental confusion. Under Health Supplies it read, family to provide personal care items, facility care team to set up, deliver and manage ordering of medications and resident would be billed by pharmacy for cost of medications. Under wellness monitoring and treatments, it read the facility care team would monitor vital signs monthly, weekly weights, blood pressure daily for medication administration and diagnosis of hypertension. The resident currently had a prescribed psychotropic medication for management of dementia and behaviors. Under medication management it read, resident may self-administer and manage medications independently or by using a medication

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Container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously if a license nurse has performed an assessment and determined the resident can perform this function safely and accurately without staff assistance. The NSA/HCS plan failed to properly identify whether the resident self-administered medications or the facility administered his medications.

Review of the September 2020 medication administration record revealed facility staff initialed all the resident's medications and treatments as being given by the staff.

Interview on 09/10/2020 at 10:20 AM with licensed nurse Q confirmed the resident lacked the ability to self-administer any of his medications and the NSA/HCS plan was not accurate.

The administrator/operator failed to ensure the negotiated service agreement accurately reflected who administered and managed this resident's medications.

- Record review for resident #262 revealed an admission date of 10/18/2017 with diagnoses of dementia, gastroesophageal reflux disease, osteopenia, urgency incontinence, hypertension and transient ischemic attack.

The annual functional capacity screen (FCS) dated 06/29/2020 identified the resident with impaired cognition in all aspects and unable to manage her own medications and treatments.

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S3186	Continued From page 18 The negotiated service agreement/healthcare service plan (NSA/HCS) dated 06/29/2020 included under Health Supplies it read, family to manage all health care supplies, facility staff to set up, deliver and manage administration of medications and the resident would be billed by pharmacy for cost of medications. Under medication management it read, resident may self-administer and manage medications independently or by using a medication Container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously if a license nurse has performed an assessment and determined the resident can perform this function safely and accurately without staff assistance. The NSA/HCS plan failed to properly identify whether the resident self-administered medications or the facility administered his medications. Review of the September 2020 medication administration record revealed facility staff initialed all the resident's medications and treatments as being given by the staff. Interview on 09/10/2020 at 10:20 AM with licensed nurse Q confirmed the resident lacked the ability to self-administer any of her medications and the NSA/HCS plan was not accurate. The administrator/operator failed to ensure the negotiated service agreement accurately reflected who administered and managed this resident's medications.	S3186		
S3202 SS=E	26-41-205 (d) (4) Delegation of Medication Administration	S3202		

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S3202	Continued From page 19 (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d)(4) The facility reported a census of 77 residents. Licensed nurse L identified 5 residents the facility certified medication aides (CMAs), performed blood sugar testing on and prepared their insulin pens with the prescribed dose for the resident to self-inject. Based on interview and record review the administrator failed to ensure a licensed nurse oriented and instructed 3 of 3 sampled CMAs (CMA A, B and C) in the performance of blood sugar testing, dialing the prescribed dose of insulin by injector pen(s) for the resident to inject and further failed to document a demonstration of the staff's competency signed by the nurse and the CMA in each employee's personnel record. Findings included: - During the entrance tour on 09/09/2020 at 2:09 PM certified medication aide (CMA) C opened the medication cart on the memory care unit for inspection. In the cart was a blood sugar testing device and an insulin pen for resident #122. CMA C reported she tested the resident's blood sugar and she prepared the insulin pen with the dose prescribed by the medical care provider for the resident to inject.	S3202		

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S3202	Continued From page 20 On 09/10/2020 at 2:55 PM licensed nurse Q confirmed the facility CMAs were delegated to perform blood sugar testing for residents and dialing insulin pens for the resident to inject. On 09/14/2020 licensed nurse L confirmed all facility CMAs assigned to pass medications were expected to test the resident's blood sugar and prepare the insulin pen for the resident to inject as follows: Resident #121 blood sugars and insulin pen setup Resident #122 blood sugars only Resident #123 blood sugars only Resident #124 blood sugars only Resident #125 blood sugars and insulin pen setup On 09/14/2020 at 3:10 PM licensed nurse L provided a notebook with single page documentation for blood sugar testing delegation for CMAs as follows: CMA A listed her first name in the same handwriting as nurse L, dated 04/12/2020, certified trainer included a first name other than nurse L and then signed by licensed nurse L. The document was not signed by the CMA to indicate the CMA's concurrence with this competency evaluation. The record failed to have evidence of insulin pen delegation with instructions, competency and co-signed by the CMA and the licensed nurse. CMA B's sheet had her name printed but no signature with a date of "04/29/30" and signed by licensed nurse L with no evidence of insulin pen delegation. CMA C's sheet had her name printed in the same handwriting as the trainer but no signature and	S3202		

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S3202	Continued From page 21 dated 03/18/2020. The name of the trainer was printed and not a signature with no identification of the trainer being a licensed nurse as able to delegate task. The record failed to have evidence of insulin pen delegation. Interview on 09/14/2020 at 3:35 PM with licensed nurse L confirmed the documents for the above CMAs (A, B and C) failed to include co-signatures by the CMA and the licensed nurse who delegated the nursing task of blood sugars. She confirmed the CMAs prepared the insulin pens for residents by attaching the needle and dialing the prescribed dose then handing to the resident who would inject the insulin into their body. She confirmed the CMAs personnel file failed to have evidence of instruction and competency in the delegated task for insulin pens. The administrator failed to ensure a licensed nurse oriented and instructed CMA D, E and F in the performance of blood sugar testing, dialing the prescribed dose of insulin by injector pen(s) and further failed to document a demonstration of the staff's competency signed by the nurse and the CMA in each employee's personnel record.	S3202		
S3320 SS=E	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in	S3320		

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S3320	Continued From page 22 existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254 (a) The facility reported a census of 77 residents. Administrator/operator O identified 13 of the 18 residents on the memory care unit as cognitively impaired and independently mobile, and 12 of the 59 residents on the assisted living unit as cognitive impairment and independently mobile. She indicated 6 of the 25 cognitively impaired and independently mobile residents had wandering behavior (5 on the memory care unit and resident (#327) on the assisted living unit). Based on observation, interview, and record review the Administrator/operator failed to ensure the facility was equipped and maintained to protect the health and safety of residents, personnel, and the public regarding unlocked chemicals.	S3320		

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S3320	Continued From page 23 Findings included: - Observation during the entrance tour on 09/10/2020 which began at 1:04 PM revealed the following safety hazards: in the south west laundry room an unlocked lower cabinet, had an opened bottle of laundry detergent labeled keep out of reach of children. At 1:30 PM the beauty shop door freely opened with visible unsecured chemicals, beauty products and supplies labeled hazardous to humans or keep out of reach of children such as; hair color, permanent kit (for making hair curly), Clorox wipes, hair spray, an isopropyl alcohol bottle, Barbicide wipes and nail polish remover. At 1:33 PM observation revealed the staff breakroom door from the resident living area hallway was opened and a bottle of CDC-10 spray disinfectant sat on the tabletop. During the memory care unit tour at 1:49 PM observation revealed a container of purple sanitation cloth wipes were in an unlocked cabinet on the north west wall of the dining area. Located in an unlocked drawer in the kitchenette by the main sink the following items were accessible to residents; 3 bottles of essential oils 1 labeled "if swallowed do not induce vomiting, call a physician or poison control" and 2 labeled to keep out of reach of children. Interview on 09/10/2020 at 1:27 PM with certified medication aide N confirmed the employee breakroom door should be closed and locked. Interview on 09/10/2020 at 1:33 PM with administrator/operator O confirmed the beauty shop should be locked. She also confirmed on 09/14/2020 all chemicals or items labeled with hazard warnings, keep out of reach of children needed to be secured/locked in a safe area.	S3320		

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S3320	Continued From page 24 The administrator/operator failed to ensure the facility was equipped and maintained to protect the health and safety of residents, personnel, and the public regarding unlocked chemicals.	S3320		