STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N085009	A. BUILDING: _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SALINA KIRWIN	1200 E KIRWIN AVENUE SALINA, KS 67401

(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 a resurvey at the above named assisted living facility conducted on 11/7,13,14/2019.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (A) (1) (2) (3) The facility reported a census of 27 residents. The sample included 3 residents and 2 focused record reviews. Based on record review and interview, the Operator failed to ensure that designated facility staff completed the Negotiated Service Agreement Addendums to include who provided the outside services the resident received, and payment source for the service for	S3085		

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

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S3085	Continued From page 1 2 (#117 and #118) of 3 sampled residents. Findings included: - Review of resident #117's medical record revealed admission date to the facility on 12/1/18 with diagnoses of hyperlipidemia, hypothyroidism, low back pain, MRSA, urinary tract infection, arthritis, cerebral infarction, depression, hypertension, tremor, Parkinson's, gastroesophageal reflux disease, insomnia, and peripheral vascular disease. Review of the Functional Capacity Screen (FCS) dated 8/27/19 recorded resident required physical assistance with bathing, toileting, dressing, transferring, eating, and management of medications and treatments. Review of the Negotiated Service Agreement (NSA) dated 8/27/19 recorded staff to provide physical assistance with bathing, dressing, toileting, transferring, and management of medications and treatments. Review of the undated Addendum revealed occupational therapy (OT) home health start of care 7/3/19. The record lacked the name of the outside provider and the payment source for the service. Addendum dated 1/9/19 revealed skilled nursing (SN) start of care 1/9/19. The record lacked the name of the outside provider and the payment source for the service. -- Review of resident # 118's medical record he admitted to the facility on 1/3/19 with diagnoses of pain, anxiety, dementia and osteoarthritis.	S3085		

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S3085	Continued From page 2 Review of the resident's functional capacity screen dated 11/4/19 revealed the resident was unable to manage his/her own medications and had a cognitive score of 4 indicating cognitive impairment. Review of the undated NSA addendum revealed home health OT start of care on 8-26-19. The addendum lacked which home health would provide the service and payment source for the service. Review of the negotiated service agreement (NSA) dated 11-4-19 revealed the the resident required physical assistance with bathing, dressing, toileting, transfers, walking and eating. The resident also had poor memory and recall ability. During an interview on 11-13-19 at 2:03 PM with licensed nursing staff B confirmed the therapy addendums needed to include who provided services and the payment source for the service. The administrator failed to ensure the negotiated service agreement include a description of the outside services the resident received, identification of the provider of each service, and identification of the party responsible for payment of the outside service for 2 (#828,829) of 3 residents.	S3085		
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 shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the	S3101		

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S3101	Continued From page 3 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 27 residents. The sample included 3 residents and 2 focused record reviews. Based on interview and record review for 2 (#117 and #118) of 3 sampled residents the operator failed to ensure each individual involved in the development of the negotiated service agreement signed the agreement. Findings included: - Review of resident #117's medical record revealed an admission date to the facility on 12/1/18 with diagnoses of hyperlipidemia, hypothyroidism, low back pain, MRSA, urinary tract infection, arthritis, cerebral infarction, depression, hypertension, tremor, Parkinson's, gastroesophageal reflux disease, insomnia, and peripheral vascular disease. Review of the Functional Capacity Screen (FCS) dated 8/27/19 recorded resident required physical assist with bathing, toileting, dressing, transferring, eating, and management of medications and treatments. It also revealed the resident had cognitive impairment. Review of the Negotiated Service Agreement (NSA) dated 8/27/19 recorded staff to provide physical assist with bathing, dressing, toileting, transferring, and management of medications and treatments. The resident did not always	S3101		

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S3101	Continued From page 4	S3101		

remember to use her call light for assistance. The NSA included the signature of the resident's legal representative, facility licensed nurse and the operator. It did not include the signature of the resident.

- Review of resident # 118's medical record he admitted to the facility on 1/3/19 with diagnoses of pain, anxiety, dementia and osteoarthritis.

Review of the resident's functional capacity screen dated 1-3-19 revealed the resident was independent with all activities of daily living except needed physical assistance with eating. The licensed nurse also screened the resident as having cognitive impairment.

Review of the admission negotiated service agreement (NSA) dated 1-3-19 revealed the staff provided assistance of 1 with eating and the resident would repeat things and had poor memory. The NSA included signatures of the residents legal representative, the licensed nurse and the operator but did not include the signature of the resident.

During an interview on 11-13-19 at 1:35 PM licensed nursing staff B reported she did an initial service plan prior to the resident moving into the facility based on observations and interviews with the resident and family. Staff B reported when the resident moved into the facility she then reviewed the service plan with the resident and family and made any changes as needed. Staff B stated she usually did not have the resident sign it if they had a power of attorney. Staff B reported both resident #117 and #118 had participated in the above listed NSAs.

Review of the Service plan policy dated 4/2015

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S3101	Continued From page 5 revealed the interdisciplinary team, the resident and their concerned party will participate in the completion of the review. The operator failed to ensure each resident that participated in the development and review of their negotiated service agreement signed it.	S3101		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 27 residents. The sample included 3 residents and 2 focused record review. Based on interview and record review the operator failed to ensure designated	S3200		

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S3200	Continued From page 6 staff administered medications and biologicals to 2 (#117 and #118) of 3 residents in accordance with professional standards of practice who received as needed (PRN) medications. Findings included: - Review of resident #117's medical record revealed admission to the facility on 12/1/18 with diagnoses of hyperlipidemia, hypothyroidism, low back pain, MRSA, urinary tract infection, arthritis, cerebral infarction, depression, hypertension, tremor, Parkinson's, gastroesophageal reflux disease, insomnia, and peripheral vascular disease. Review of the Functional Capacity Screen (FCS) dated 8/27/19 revealed the LPN or CMA to assist the resident with medications. Review of the Negotiated Service Agreement (NSA) dated 8/27/19 directed licensed or certified staff to administer and perform all tasks related to administering medications and treatments. Review of the physician's orders revealed an order for Hydrocodone-Acetaminophen (Norco) (narcotic for pain) 5/325 milligrams (mg) every 4 hours as needed (PRN) for pain. Review of the November 2019 medication administration record (MAR) recorded resident received Norco on 7 times. The record lacked evidence of notification of licensed nurse prior to administration of PRN medication and the reason why the medication was administered. - Review of resident # 118's medical record he admitted to the facility on 1/3/19 with diagnoses of pain, anxiety, dementia and osteoarthritis.	S3200		

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S3200	Continued From page 7 The functional capacity screen dated 11/4/19 revealed the resident was unable to manage his/her own medications and had a cognitive score of 4 indicating cognitive impairment. Review of the negotiated service agreement dated 11-4-19 revealed the facility staff to manage all tasks related to medications and treatments and that the resident had poor memory and recall ability. . Review of the resident record included the following medication orders: 1/3/19 - Tylenol 8 hour arthritis 650 mg give 1300 mg every 8 hours as needed for pain related to osteoarthritis. 1/3/19 - Naproxen Sodium tablet 220 mg 1 tablet every 12 hours as needed related to acute pain 1/3/19 - Tramadol HCL 50 mg tablet give 1 every 12 hours as needed for acute pain. discontinue date of 10/17/19. 7/1/19 - Alprazolam tablet 0.25 mg every 12 hours related to anxiety disorder. Discontinue date of 10/17/19. 10/17/19 - Alprazolam 0.5 mg tablet every 8 hours as needed for hollering out, striking our, refusal of cares related to anxiety. 10/26/19 - Lorazepam intensol 2 mg/ml give 0.5 ml every 6 hours as needed for anxiety. 10/30/19 - Morphine Sulfate 20 mg/ml give 0.25 ml every 4 hours as needed for acute pain. 11/2/19 - Lorazepam intensol 2 mg/ml give 1 ml every 6 hours as needed related to anxiety. Review of the residents medication administration record (MAR) for October 2019 revealed the resident received the following PRN medications: Alprazolam 0.25 mg 6 times; Lorazepam Intensol 0.5 ml 5 times; Naproxen 220 mg 9 times;	S3200		

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S3200	Continued From page 8 Tramadol 50 mg 10 times; Tylenol arthritis pain 1300 mg 3 times;and Alprazolam 0.5 mg 8 times. Review of the November 2019 MAR revealed the resident received the following PRN medications: Lorazepam intensol 0.5 ml 2 times; Lorazepam intensol 1 ml 8 times; Morphine Sulfate .25 ml 3 times; Naproxen 220 mg 2 times; Tylenol arthritis 1300 mg 2 times; and Alprazolam 0.5 mg 13 times. Each MAR lacked evidence of why the PRN medication was administered and that the nurse was notified prior to administration of the medication. During an interview on 11/13/19 at 1:26 PM certified staff J reported when a resident asked for a PRN medication she checked to make sure they could have it. Staff J reported if the nurse was in the building she usually told the nurse prior to giving the medication but if the nurse is not in the building she would either leave a sticky note or text her on the work phone to let her know of all of the PRN medications she gave on her shift. During an interview on 11-13-19 at 2:40 PM certified staff K reported certified staff needed to contact the nurse any time a resident wanted a PRN medication before certified staff could administer it. During an interview on 11-13-19 at 1:34 PM licensed nursing staff B reported the expectation for administration of PRN medications is for the staff to call me prior to administering any narcotic or psychotropic medication. If it is Tylenol or something like that they do not have to call me. Certified staff are also supposed to include in the MAR progress notes why the medication was	S3200		

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S3200	Continued From page 9 administered and interventions staff tried before administering a psychotropic medication. Review of the medication policy dated 11/2018 revealed when a resident requested a PRN medication the documentation on the MAR should include the date, time, the reason given and the initials of the associate. It also included if the resident had cognitive impairment the unlicensed associate should notify the nurse before giving the medication. The operator failed to ensure designated staff administered medications and biologicals in accordance with professional standards of practice related to PRN medications.	S3200		
S3320 SS=F	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and	S3320		

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S3320	Continued From page 10 (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 27 residents. The sample included 3 residents and 2 focused reviews. Based on observation and interview with staff, the operator failed to ensure the facility was maintained to protect the health and safety of the residents when chemicals were unsecured under the dining room sink. Findings included: - Observation during initial tour on 11/14/19 revealed facility's dining room sink cabinet unlocked at 10:09 AM with the door shut, unlocked, and it opened easily. The unlocked cabinet contained the following chemicals: a bottle of disinfectant spray, a spray can degreaser cleaner, and spray glass cleaner. Interview on 11/7/19 at 10:09 AM with licensed nursing staff C confirmed chemicals were not to be stored under the unlocked dining room sink and staff C removed the chemicals. Review of the facility chemical storage policy recorded, "All supply closets that store chemicals should be locked when not in use. Chemicals should never be left unattended. For all residents, the operator failed to ensure the facility was maintained to protect the health and safety of the residents when chemicals were	S3320		

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S3320	Continued From page 11 unsecured under the dining room kitchen sink.	S3320		