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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of the licensure resurvey and complaint investigations #135804 and #136529 for the above named facility conducted on 9/18/19 and 9/24/19. | S 000 | | |
| S3155 SS=E | 26-41-204 (a) Health Care Services<br><br>. (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.<br><br>This REQUIREMENT is not met as evidenced by: KAR 26-41 204 (a)<br><br>The facility reported a census of 15 residents. The sample included 3 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 which met the needs for 2 of 3 sampled residents (#579 and #811) related to a lack of reviewing falls for causal factors and developing appropriate interventions to reduce the risk for further falls and the use of bed assistive devices/rails.<br><br>Findings included: | S3155 | | |

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

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- Record review for resident #579 revealed an admission dated of 10/28/17 with diagnoses of hypertension, prolapsing mitral valve, chronic angina pectoris, coronary artery disease, anxiety, pain, depression, anemia and insomnia.

The annual functional capacity screen dated 10/29/18 indicated the resident had short-term memory deficit and impaired decision making. He/she needed physical assistance with bathing, dressing, toileting, walking and mobility and supervision with transfers between surfaces. She was marked as a fall risk and used an assistive device (cane, walker, crutches) and a wheelchair.

Review of the negotiated service agreement/health care plan (NSA/HCP) dated 10/29/18 revealed the facility provided staff assistance with bathing, dressing, toileting (SBA - stand by assist and walker), mobility (SBA), and supervision by SBA when transferring for safety. The NSA/HCP indicated the resident used a walker and a wheelchair only when having increased weakness. The resident had fallen in the past 180 days and included a fall on 9/30/18 of a fall in the room with directions to place the walker within reach in case the resident unhooked the alarm. Under other nursing needs - resident had a personal alarm on at all times per family request to prevent falls.

Review of the nursing notes between 12/26/18 and 9/06/19 revealed the resident experienced 3 falls in 2019 as follows:
On 5/12/19 at 9:00 AM certified medication aide (CMA) L wrote at 7:00 AM she went to assist the resident up for the day and the resident complained of right wrist pain. The right wrist showed signs of bruises and swelling. The

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resident said she had sat on the side of the bed during the night to use the bathroom and fell forward. The note did not indicate if the planned personal alarm was in place, functioning or when the resident was last provided care. On 9/18/19 a request to review the facility investigation for causal factors and actions taken to reduce the risk of further falls resulted in operator D not having an investigation.

Nursing note on 7/13/19 at 1:00 PM CMA L wrote at 11:45 AM another staff alerted her to the resident falling. She observed the resident on the floor on her right side with blood coming from her mouth. The resident stated, she had hit her nose and mouth on the night stand. The note indicated the resident went to the emergency room by ambulance to be checked and returned without any new orders. The facility investigation indicated the bed alarm did sound and staff responded finding the resident on the floor. The resident indicated she was getting up to go to the bathroom had turned to shut the alarm off and fell. The investigation did not identify when staff had last visualized or provided assistance with toileting for the resident. Interventions included moving the bedside table, education of resident to use call light and sit down when the alarm sounds. On 9/18/19 at 4:10 PM a discussion with licensed nurse F confirmed the education/expectation for the resident with short-term memory deficit and impaired decision making to remember to call for help or sit down when the alarm sounded was an inappropriate intervention.

Nursing note on 9/03/19 at 10:00 PM by licensed nurse F indicated she was notified by staff the resident had fallen in the bathroom and struck her

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| S3155 | Continued From page 3<br>head on the wall. The family was notified and took the resident to the emergency room for evaluation. On 9/14/19 at 1:10 AM the resident returned to the facility per family transport. Review of the facility fall investigation revealed the resident got up from the toilet without assistance and while ambulating to the sink she fell striking her head on the wall. She said, she was starting to move, and the walker went one way and she went the other. The investigation did not indicate whether staff were present in the bathroom to provide the planned stand by assistance, if the staff was in the bedroom portion of the room and not available to provide assistance. The intervention - resident re-educated on the use of the call light and waiting for assistance prior to getting on or off the toilet or ambulating without assistance. On 9/18/19 at 4:10 PM a discussion with licensed nurse F confirmed the education/expectation for the resident with short-term memory deficit and impaired decision making to remember to call for help and wait for assistance was an inappropriate intervention.<br><br>Observation on 9/18/19 at 12:33 PM revealed CMA G assisted the resident to ambulate with a walker and SBA from the dining room table to her room and then into the bathroom. The resident was highly active in the task of walking, moving her walker, and using the safety rail at the toilet while CMA G assisted with her clothing. CMA G remained in the bathroom with the resident and the resident indicated she did not mind stay staying in the room with her. She said she can get up and do things for herself, but the staff want to help to. She said she takes a shower by herself, dresses and does pretty much whatever she wants to. | S3155 | | |

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| S3155 | Continued From page 4<br>Interview on 9/18/19 at 12:33 PM with CMA G revealed staff should assist the resident with all transfers, ambulation and toileting.<br><br>The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which me the needs of this resident regarding this resident's fall risk and repeated falls.<br><br>- Record review for resident #811 revealed an admission date of 5/22/19 with diagnoses of Parkinson, hypertension, depression, vitamin D deficiency, anemia and glaucoma.<br><br>The admission functional capacity screen (FCS) dated 5/22/19 indicated the resident had intact cognitive function, needed physical assistance with bathing, dressing, toileting and supervision for walking but independent with transfers between surfaces. The FCS did not identify the use of a bed assistive device or the overhead trapeze.<br><br>Record review revealed no assessment for the use of a bed assistive device/rail to confirm the device was not a restraint, an assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment. The record also lacked an assessment for the safe use of an overhead trapeze assistive device attached to the bed.<br><br>The negotiated service agreement/health care plan (NSA/HCP) dated 5/22/19 indicated facility staff would assistance with personal care, bathing, | S3155 | | |

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dressing, toileting and the resident required cueing to ambulate safely when walking in halls and dining room. The resident could transfer between surfaces independently with the use of a walker. The NSA/HCP failed to include any information about the use or safety of a bed rail/assistive device, or the overhead trapeze device attached to the bed.

Review of the nursing notes between 5/22/19 and 8/13/19 at 5:00 PM (last entry) revealed no information about the use of the bed rail/assistive device, overhead trapeze device or safety of the devices used.

Observation on 9/18/19 at 1:22 PM revealed the resident's bed had an over the bed trapeze transfer aide attached to the bed and a full bed rail on the side next to the wall. The bed rail extended from the head of the bed to the foot of the bed and the gap between each of the rails measured greater than 5 inches creating a risk for entrapment of her extremities.

Interview on 9/18/19 at 1:45 PM with licensed nurse F confirmed she had not completed an assessment of the bed assist devices. She confirmed the NSA/HCP did not address the resident's use of bed assist devices.

The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows:
Zone 1 within the rail should measure less than 4 and 3/4 inches

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| S3155 | Continued From page 6<br>Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches<br>Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches<br>Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches.<br><br>The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident regarding use of a bed assistive device/bed rail. | S3155 | | |
| S3200 SS=E | 26-41-205 (d) (1-2) Facility Administration of Medications<br><br>(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:<br>(1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility.<br>(2) Medication aides shall not administer medication through the parenteral route. | S3200 | | |

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| S3200 | Continued From page 7<br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-205 (d)<br><br>The facility reported a census of 15 residents. The sample included 3 residents. Based on record review and interview the operator failed to ensure that all medications and biologicals were administered to each resident which the facility managed in accordance with a medical care provider's written order for 2 of 3 sampled residents (#579 and #682).<br><br>Findings included:<br><br>- Record review for resident #682 revealed an admission date of 8/1/14 with diagnoses of diabetes mellitus 2, hypertension, atrial fibrillation, coronary artery disease, pulmonary hypertension, heart palpitations, hypothyroidism, hyperlipidemia, hypokalemia and neuropathy.<br><br>The annual functional capacity screening (FCS) dated 1/10/19 identified the resident with intact cognitive function, independent with activities of daily living except bathing which required physical assistance. She was assessed to be able to manage her own medications and treatments.<br><br>The negotiated service agreement/health care plan (NSA/HCP) dated 1/10/19 directed staff to administer the resident's medications as order by the physician and the resident could self-administer Tylenol, Imodium, vapor rub, refresh eye drops, and hydrocortisone cream as ordered.<br><br>Record review revealed a recapitulation of the medical care provider's orders signed on 6/10/19. | S3200 | | |

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| S3200 | Continued From page 8<br>The orders included medications which when compared to the September 2019 medication administration record (MAR) did not match as follows:<br>The MAR had Avapro 300 mg (milligrams) 1/2 tab by mouth twice a day (BID) for hypertension but the orders signed 6/10/19 did not include this order.<br>The MAR had Lasix 20 mg 1.5 tablets by mouth every day for edema, but the orders signed 6/10/19 read Lasix 40 mg 1 tablet by mouth daily. The record lacked any phone, fax or hand-written orders changing the Lasix.<br>The MAR had fish oil 1040 mg 1 tablet by mouth every day for heart health. The orders signed 6/10/19 had fish oil 1,000 mg 1 tablet by mouth every day.<br><br>A hand-written medical care provider's order dated 8/08/19 directed staff to administer Alprazolam 0.5 mg 1 every 8 hours PRN (as needed) for anxiety. Review of the September MAR revealed no order transcribed. Interview on 9/18/19 at 4:05 PM with licensed nurse F revealed the resident had a death in the family and the medical care provider visited on 8/08/19 and wrote the order for the PRN alprazolam but nurse F understood the order was just for the day before, day of and day after the funeral so she did not transcribe the order onto the September MAR. She confirmed the order written did not specify the limited use and she confirmed not contacting the medical care provider to clarify the order.<br><br>Review of the nursing notes between 9/06/18 and 9/06/19 (last note) revealed an entry dated 11/22/18 at 8:00 AM (unreadable staff signature) - | S3200 | | |

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resident took her medications and another resident's medications, nurse notified and said to do every 30-minute VS (vital signs). ... An entry dated 11/22/18 at 10:15 AM family member was notified of the need to take the resident to the hospital for taking the wrong medications. The next entry dated 11/22/18 at 10:15 AM indicated the resident would stay at the hospital all night. The next entry dated 11/22/18 at 2:00 PM resident returned to the facility with no new orders and return to all normal medications. An entry dated 11/23/18 at 10:00 AM by licensed nurse E indicated the resident received her own 8:00 AM medications which consisted of metformin (diabetic med), Avapro (B/P), diltiazem (B/P), klor-con (potassium), hydralazine (diuretic), atenolol (B/P), Pepcid (acid reflux), Lasix (diuretic), Preds (vision vitamin), vitamin D3, and Colace (stool softener). She also took another resident's medications which included Celexa (antidepressant), aspirin, Colace, gabapentin (neuropathy), Plavix (anti-clotting), isosorbide (B/P), diltiazem (B/P), bumetanide (diuretic), loratadine (allergies) and guaifenesin (expectorant). ...

On 9/18/19 operator D provided a single page document when the surveyor requested to review the investigation into the causal factors of the medication error. The document included information about retraining of certified medication aide K

A nursing note dated 4/19/19 at 8:00 AM by licensed nurse J indicated the nurse noted a medication error occurred on the evening of 4/18/19, the nurse notified the medical care provider, the durable power of attorney and the

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resident. ... The medical care provider gave orders to administer the Medrol-Pak (steroid) on a new schedule.

On 9/18/19 a request was made to review the facility's investigation of the medication error which occurred on 4/18/19 and evidence of actions taken to reduce the risk of further medication errors. Operator D reported she could not find any investigation.

The operator failed to ensure that all medications and biologicals were administered to this resident in accordance with a medical care provider's written order.

- Record review for resident #579 revealed an admission dated of 10/28/17 with diagnoses of hypertension, prolapsing mitral valve, chronic angina pectoris, coronary artery disease, anxiety, pain, depression, anemia and insomnia.

The annual functional capacity screen (FCS) dated 10/29/18 indicated the resident had short-term and impaired decision making. She needed physical assistance to manage her own medications.

The negotiated service agreement/health care plan (NSA/HCP) dated 10/29/18 directed staff to administer the resident's medication per a medical care provider's order and the resident could self-administer mentholatum.

Review of the record on 9/18/19 revealed a recapitulation of the medical care provider's orders signed 9/13/9 and compared to the original order signed 10/28/17 revealed an order for Tums

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| S3200 | Continued From page 11<br>(antacid-calcium) 500 mg (milligrams) tablet chew 2 every day for upset stomach. The order did not read PRN but was under the section of PRN medications. The original order 10/28/17 did read PRN. The September 2019 medication administration record read - Tums (no strength) 2 chewable by mouth every day PRN for upset stomach.<br><br>Interview on 9/18/19 at 4:10 PM with licensed nurse F confirmed the September 2019 MAR did not have the strength of the Tums and she had missed that in the transcription of the orders which is done month to month in the computer.<br><br>The operator failed to ensure that all medications and biologicals were administered to this resident in accordance with a medical care provider's written order. | S3200 | | |
| S3202 SS=E | 26-41-205 (d) (4) Delegation of Medication Administration<br><br>(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.<br><br>This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) (4)<br><br>The facility reported a census of 15 residents. The personnel record review included 4 certified medication aides (CMA). Based on interview and record review the operator failed to ensure a | S3202 | | |

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licensed nurse oriented and instructed 4 of 4 sampled CMAs, (CMA B and F) in the performance of blood sugar testing 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 conference on 9/18/19 licensed nurse F reported certified medication aides (CMAs) were delegated to perform blood sugar testing for residents.

Review of the personnel file for CMA B on 9/18/19 revealed she began employment on 1/04/19 and the record lacked documentation of additional training to allow this CMA to perform blood sugar testing.

Review of the personnel file for CMA H revealed she began employment on 7/26/19 and the record lacked documentation of additional training to allow this CMA to perform blood sugar testing.

Review of the personnel file for CMA C revealed she began employment on 11/19/18 and the record lacked documentation of additional training to allow this CMA to perform blood sugar testing.

Upon request from licensed nurse E she confirmed CMA G on duty 9/18/19 did not have documentation of additional training to allow this CMA to perform blood sugar testing.

Interview on 9/18/19 at 11:17 AM with CMA H revealed she performed blood sugar testing for residents who had a medical care provider's order

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| S3202 | Continued From page 13<br>for them.<br><br>Interview on 9/18/19 at 4:20 PM with operator/licensed nurse E confirmed all the CMAs employed by the facility were expected to perform blood sugar testing. He/she confirmed the personnel files for CMA B, C, G and CMA H lacked evidence of further training/competency to allow them to perform blood sugar testing.<br><br>The operator failed to ensure a licensed nurse oriented and instructed CMAs in the performance of blood sugar testing 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 | | |
| S3211 SS=E | 26-41-205 (g) (3) OVER THE COUNTER DRUGS<br><br>(3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-205 (g) (3) | S3211 | | |

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| S3211 | Continued From page 14<br><br>The facility reported a census of 15 residents. Based on observation and interview the operator failed to ensure a licensed nurse or licensed pharmacist labeled over-the-counter medications with the resident's full name for residents whom the facility managed his/her medications (#174, #210, #202, #579, #213, #307, #682 and #811).<br><br>Findings included:<br><br>- On 9/18/19 at 11:17 AM certified medication aide (CMA) G opened the only medication room and medication cart. Observation revealed over-the-counter (OTC) medications for multiple residents. The OTC medications lacked proper labeling with resident's full name as follows:<br>Resident #174 had 8 OTC medications which had no identification at all or had a last name or a first name which CMA G identified the unmarked bottles as belonging to the resident.<br>Resident #201 had a bottle of OTC acetaminophen which had his/her first name and the first name of his/her spouse.<br>Resident #307 had 4 OTC medications labeled with first name and last name initial, or initials only.<br>Resident #682 had 3 OTC medications labeled with first initial and last name, last name only or just initials.<br>Resident #213 had 4 OTC medications labeled with first name and last initial or last name only.<br>Resident #579 had 3 OTC medications labeled with initials, first initial and last name or first name and last initial.<br>Resident #202 had 4 OTC medications without any labeling, first initial and last name or first name only. | S3211 | | |

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| S3211 | Continued From page 15<br>Resident #811 had 4 OTC medications without any labeling and identified as belonging to the resident by CMA G, initials or first name and last initial.<br><br>Interview on 9/18/19 at 11:17 AM with CMA G revealed an expectation for whoever received the medication to write the resident's name on the OTC when the resident or family brought the OTCs to them.<br><br>Interview on 9/18/19 at 11:40 AM with licensed nurse F revealed she was not aware of the regulation for a licensed nurse or licensed pharmacist to label the OTC medications with the resident's full name.<br><br>The operator failed to ensure a licensed nurse or licensed pharmacist labeled over-the-counter medications with the resident's full name. | S3211 | | |
| S3215 SS=E | 26-41-205 (h) Medication Storage<br><br>(h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations.<br>(1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed | S3215 | | |

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| S3215 | Continued From page 16<br>nurses and medication aides shall have access to the stored medications and biologicals.<br>(2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides.<br>(3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility.<br>(4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-205 (h) (4)<br><br>The facility reported a census of 15 residents and a licensed capacity of 34 residents. The operator failed to ensure a licensed nurse could not administer medication beyond the manufacturer's or pharmacy provider's recommended date of expiration for an opened bottle of tuberculosis testing solution.<br><br>Finding included:<br><br>- On 9/18/19 at 11:56 AM certified medication aide G opened the only medication room and medication refrigerator. Observation revealed an opened bottle of tuberculosis testing solution without a date of when opened on the bottle. The dispensing date from the pharmacy read 8/12/19. | S3215 | | |

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| S3215 | Continued From page 17<br><br>Interview on 9/18/19 at 11:58 AM with licensed nurse F revealed she opened the bottle the day it was delivered. She confirmed not dating the bottle when she opened it and was not aware of the shortened expiration date once the bottle was opened. She confirmed the testing solution could have been used for any newly admitted residents and annual testing of residents.<br><br>The FDA (Federal Drug Administration) tuberculosis (tubersol) package insert directed the tubersol testing solution would expire 30 days after the date of opening.<br><br>The operator failed to ensure a licensed nurse could not administer medication beyond the manufacturer's or pharmacy provider's recommended date of expiration for an opened bottle of tuberculosis testing solution. | S3215 | | |
| S3248 SS=F | 26-41-102 (d) Staff Qualifications Employee Records<br><br>(d) The employee records and agency staff records shall contain the following documentation:<br>(1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training;<br>(2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto;<br>(3) supporting documentation from the Kansas | S3248 | | |

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| S3248 | Continued From page 18<br>nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide.<br><br>This REQUIREMENT is not met as evidenced by: KAR 26-41-102 (d)(1)(3)<br><br>The facility reported a census of 15 residents. Based on interview and record review the operator failed to have evidence of criminal background checks for 2 of 4 certified staff reviewed (certified medication aide B and C), and verification of nurse aide registry verification for 3 of 4 certified staff reviewed (certified nurse aide A and certified medication aide B and C) as required to ensure the individual did not have a finding of abuse/neglect/exploitation. The 3 certified staff had the potential to provide care to all the residents.<br><br>Findings included:<br><br>- Personnel record review on 9/18/19 at 3:55 PM revealed the personnel record for certified medication aide (CMA) B revealed she began employment on 1/04/19. The personnel file lacked evidence of a criminal background check and the nurse aide registry verification was conducted on | S3248 | | |

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| S3248 | Continued From page 19<br>1/06/19 after she began employment and provided resident care.<br><br>The personnel record for CMA C indicated she began employment on 11/19/18 with no evidence of a criminal background check and the nurse aide registry verification did not occur until 9/18/19.<br><br>The personnel record for certified nurse aide (CNA) A indicated she began employment on 4/22/19 and did not have nurse aide registry verification until 5/16/19.<br><br>On 9/18/19 at 4:20 PM operator E confirmed the record lacked evidence of criminal background checks for CMA B and C and nurse aide registry verification for CNA A, CMA B and C.<br><br>The operator failed to have evidence she requested a criminal background check and verified the nurse aide registry for 3 of 4 certified staff hired since the last survey before the staff began providing care to the residents ( CNA A, CMA B and C) who had the potential to provide care to all the residents. | S3248 | | |
| S3280 SS=E | 26-41-104 (d) Disaster and Emergency Preparedness<br><br>(d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following:<br>(1) Orientation of new employees at the time of employment to the facility ' s emergency management plan;<br>(2) education of each resident upon | S3280 | | |

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| S3280 | Continued From page 20<br>admission to the facility regarding emergency procedures;<br>(3) quarterly review of the facility ' s emergency management plan with employees and residents; and<br>(4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-104 (d) (3)<br><br>The facility reported a census of 15 residents. Based on interview and record review the operator failed to ensure staff and residents had disaster and emergency preparedness by a failure to conduct a quarterly review of the facility's emergency management plan.<br><br>Findings included:<br><br>- On 9/18/19 at 4:15 PM the surveyor requested the documentation for training/review of the facility's emergency management plan with residents and staff conducted every quarter since the last survey conducted on 4/26/18.<br><br>Operator D provided documentation of staff review done on 5/18/19 and 7/30/19. Review of the information review for the management plan revealed the operator failed to cover all the required elements and lacked a review of severe weather, explosion, natural gas leak, lack of water service or missing resident. | S3280 | | |

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| S3280 | Continued From page 21<br><br>On 9/18/19 at 4:20 PM operator D confirmed she could not find any documentation of the emergency plan review conducted with the resident since the last survey.<br><br>The operator failed to ensure staff and residents had disaster and emergency preparedness by a failure to provide information for a quarterly review on the facility's emergency management plan. | S3280 | | |