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	N070008	A. BUILDING: _____ B. WING _____	06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE RETIREMENT COMMUNITY ASSISTED L	702 W 7TH PO BOX 308 OVERBROOK, KS 66524

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 6/26/19 and 6/27/19.	S 000		
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 17 residents. The sample included 3 residents. The facility identified 14 residents received medication management by the facility. Based on observation, interview and record review the administrator/operator failed to ensure 3 of 3 sampled resident's (#768, #879 and #922) medications and/or biologicals were administered	S3200		

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

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S3200	Continued From page 1 in accordance with a medical care provider's written orders and professional standards of practice regarding consultation with a nurse before administration of PRN (as needed) medications by certified medication aides. Findings included: - Record review for resident #879 revealed an admission date of 6/27/18 with diagnoses of pain right shoulder, chronic fatigue, unspecified dorsalgia (back pain, backache or spine pain), unspecified kidney failure, cardiac pacemaker, hypertension, chronic ischemic heart disease and atrial fibrillation. Review of the significant change functional capacity screen (FCS) dated 7/12/18 and compared to the annual FCS dated 6/18/19 indicated the resident had a change in cognition from intact cognition to impairment with short-term memory and memory/recall. On both FCS he/she needed physical assistance with medication and treatment management. The negotiated service agreement/health care services plan dated 6/18/19 directed staff to administer the resident his/her medications. Review of the recapitulation of the medical care provider's orders signed on 4/23/19 revealed the following medication orders for unspecified dorsalgia: acetaminophen 500 milligrams (mg) 2 tablets by mouth at bedtime (HS) PRN (as needed) for unspecified dorsalgia. alternate heat and ice PRN for neck and back pain 4 times a day PRN gabapentin 300 mg 1 capsule by mouth every evening	S3200		

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S3200	Continued From page 2 fentanyl patch 75 micrograms/hour 1 patch every 3 days diclofenac sodium (Voltaren gel) to right shoulder topically 3 times a day PRN A fax sent to the medical care provider on 5/28/19 read - resident complained of pain to both ankles, right worse and right shoulder - currently doing Voltaren gel 3 times a day PRN and Tylenol (acetaminophen 500 mg PRN once daily. May we schedule the Tylenol? The medical care provider responded Tylenol 1,000 mg by mouth twice a day. At the time of this fax (5/28/19 at 10:30 AM) the medical care provider's orders did not include a Tylenol 500 mg once daily PRN order. Review of the electronic medication order set-up for administration times revealed on 5/28/19 licensed nurse D entered a order for acetaminophen 500 mg tablets give 2 tablets twice a day with administration times of 6:00 AM - 10:00 AM and 4:00 PM - 7:00 PM. Observation on 6/26/19 at 11:43 AM revealed certified medication aide (CMA) C approached the resident in the dining room and asked the resident if he/she was hurting at all and if the resident needed a Tylenol. The resident responded "yes" and CMA C replied, "Okay, I'll get you some". CMA C left the dining room area and went directly to the medication room. At 11:47 AM CMA C returned to the dining room and administered the resident's medications. He/she reported giving the resident his/her scheduled noon medications and PRN Tylenol for shoulder pain. Interview on 6/26/19 at 12:05 PM with licensed nurse D revealed an expectation for CMAs to	S3200		

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consult with him/her before administration of PRN medications and confirmed he/she was not consulted before the administration of the PRN Tylenol for resident #879.

Review of the medication administration record (MAR) for May 2019 revealed the resident received Tylenol/acetaminophen 500 mg 2 tablets PRN 15 times other than bedtime. The reason listed included right shoulder pain, bilateral lower extremities, both ankles and right shoulder, hurt all over and some with no reason recorded. None of the documentation indicated the CMA had consulted with the nurse prior to administration of the PRN medication with a diagnosis for use of unspecified dorsalgia (back pain, backache, spine pain).

The June 2019 MAR included the documentation by CMA C of PRN Tylenol at 11:47 AM for pain. Following the conversation with licensed nurse D about the PRN being given and no nurse consultation CMA C made a further note at 12:40 PM of right shoulder pain, nurse notified.

Review of the nursing notes between 6/28/18 at 1:56 PM through 6/26/19 at 1:05 PM no entries of the nurse being consulted prior to administration of PRN medications. On 6/26/19 at 1:05 PM licensed nurse D recorded - "resident complained of pain to CMA around lunch time - PRN Tylenol given to resident - notified physician of above and requested order clarification on the PRN Tylenol to change PRN administration to once daily and to ask for clarification regarding time frame between doses".

Interview with licensed nurse D on 6/26/19 at 1:03 PM revealed he/she had directed CMA C to make the note and confirmed he/she was not consulted

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about the resident's pain prior to the CMA administration of the Tylenol PRN which was order for an HS administration. He/she further confirmed the resident had received the morning scheduled 1,000 mg of acetaminophen at 7:58 AM. He/she confirmed the acetaminophen order did not identify a specific use of right shoulder pain and needed clarified on a frequency other than just bedtime.

The administrator/operator failed to ensure this resident's medication and/or biologicals were administered in accordance with a medical care provider's written orders and professional standards of practice regarding consultation with a nurse before administration of PRN (as needed) medications by certified medication aides.

- Record review for resident #922 revealed an admission date of 3/31/18 with diagnoses of cerebral infarct, atrial fibrillation, disorientation unspecified, hypertension, urinary retention, gout, long term use of anticoagulant, obesity and skin cancer.

The annual/significant change functional capacity screen dated 5/02/19 identified the resident with impaired long-term memory and memory recall. He/she needed physical assistance with medications and treatments.

The negotiated service agreement/health care service plan dated 5/02/19 directed staff to administer the resident's medications.

Review of the medical care provider's orders revealed an order dated 3/31/18 for acetaminophen 500 milligrams (mg) 1 tablet by mouth every 6 hours PRN (as needed) for mild

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S3200	Continued From page 5 pain and a diagnosis of gout. Review of the June 2019 medication administration record (MAR) revealed certified medication aides (CMA) administered acetaminophen 500 mg PRN 6 times for reasons of pain bilateral hips, pain bilateral hips and back, hips and lower back, right hip and right knee, right hip and some without any reason listed. None of the documentation indicated the nurse was consulted by the CMAs before administration of the PRN medication and none for a report of gout pain (is caused by a buildup of uric acid and with have swelling and pain in the joints of the foot, particularly the big toe). Review of the nursing notes between 5/02/19 11:58 AM and 6/26/19 at 1:11 PM revealed no documentation of the CMA consulting with the nurse prior to PRN medication administration as listed above. Interview on 6/26/19 at 12:05 PM with licensed nurse D revealed an expectation for CMAs to consult with him/her before administration of PRN medications. He/she confirmed the documentation did not reflect the nurse being consulted prior to administration of PRN acetaminophen for this resident. The administrator/operator failed to ensure this resident's medications and/or biologicals were administered in accordance with a medical care provider's written orders and professional standards of practice regarding consultation with a nurse before administration of PRN (as needed) medications by certified medication aides. - Record review for resident #768 revealed an	S3200		

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admission date of 4/25/15 with diagnoses of hypertension, history of fractures and pathological fractures, cellulitis of left lower limb, disorder of the skin and subcutaneous tissues, low back pain, muscle weakness, and degenerated conditions of globe vertebra (the first cervical vertebra of the spine).

The annual functional capacity screen dated 4/08/19 identified the resident with impaired short-term memory and memory recall. He/she needed physical assistance with medications and treatments.

The negotiated service agreement/health care service plan dated 4/08/19 directed staff to administer the resident's medications.

Review of the medical care provider's orders revealed an order for acetaminophen 325 milligrams (mg) 2 capsules every 4 hours PRN (as needed) by mouth for mild pain or fever and diagnosis of low back pain.

Review of the June 2019 medication administration record (MAR) revealed the resident received the PRN acetaminophen 24 times in June 2019 with reason listed of pain right side, pain in back, pain lower back, pain lower back right side, see diagnosis and some were blank. None of the documentation through 6/26/19 at 7:56 AM indicated the CMA had consulted with a nurse prior to administration of a PRN medication for various areas of pain.

Review of the nursing notes between 4/30/19 at 1:39 PM and 6/26/19 at 11:34 AM revealed no entries regarding the CMA consulted with the nurse prior to administration of PRN medication.

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S3200	Continued From page 7 Interview on 6/26/19 at 12:05 PM with licensed nurse D revealed an expectation for CMAs to consult with him/her before administration of PRN medications. He/she confirmed the documentation did not reflect the nurse being consulted prior to administration of PRN acetaminophen for this resident. The administrator/operator failed to ensure this resident's medications and/or biologicals were administered in accordance with a medical care provider's written orders and professional standards of practice regarding consultation with a nurse before administration of PRN (as needed) medications by certified medication aides.	S3200		
S3202 SS=E	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) (4) The facility reported a census of 17 residents. The personnel record review included 2 certified medication aides (CMA). Based on interview and record review the administrator/operator failed to ensure a licensed nurse oriented and instructed 2 of 2 sampled CMAs, (CMA J and K) and 1 focused CMA review (CMA C) in the performance of blood sugar testing, dialing the	S3202		

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S3202	Continued From page 8	S3202		

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 conference on 6/26/19 at 10:30 AM licensed nurse D reported certified medication aides (CMAs) were delegated to perform blood sugar testing for residents and dialing insulin pens for the resident to inject.

Review of the personnel file for CMA A on 6/26/19 at 3:05 PM revealed he/she began employment on 12/14/18 and currently still employed. The record lacked documentation of additional training to allow this CMA to perform blood sugar testing and dialing the prescribed dose on the resident's insulin pen(s).

Review of the personnel file for CMA B revealed he/she began employment on 1/22/18 and currently still employed. The record lacked documentation of additional training to allow this CMA to dial the prescribed dose on the resident's insulin pen(s).

Interview on 6/26/19 at 9:40 AM with CMA C revealed he/she performed blood sugar testing for resident's who had a medical care provider's order for them. He/she dialed the dose of insulin as prescribed by the medical care provider for the resident and handed the pen to the resident who self-injected.

Interview on 6/26/19 at 3:10 PM with licensed nurse D confirmed all the CMAs employed by the facility were expected to perform blood sugar

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S3202	Continued From page 9 testing and dial the dose of insulin for residents which the facility managed medications/treatments. He/she confirmed CMA A personnel file lacked evidence of further training/competency to allow them to perform blood sugar testing and dialing of insulin pens. He/she confirmed CMA B's personnel file lacked evidence of further training/competency to allow them to dial the dose and prep the insulin pens for the resident to inject. He/she also reported a lack of evidence for CMA C of further training/competency to allow them to perform blood sugar testing and dialing of insulin pens. The administrator/operator failed to ensure a licensed nurse oriented and instructed CMA A, B and C 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		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container.	S3211		

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S3211	Continued From page 10 This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 17 residents and the facility managed medications for 14 of those residents. Based on observation and interview the administrator/operator failed to ensure a licensed nurse or licensed pharmacist labeled over-the-counter medications with the resident's full name. Findings included: - The resident roster provided on 6/26/19 indicated the facility managed medications/treatments for 14 residents. On 6/26/19 at 9:26 AM certified medication aide (CMA) C opened the locked medication room door and indicated the cabinetry within held all the resident's medications. Observation of the medication storage revealed the following residents had over-the-counter (OTC) medications which were not labeled with the resident's full name: Resident #510 had 3 opened bottles which were labeled with the resident's first name and last initial only and 1 open bottle without a name which staff had wrote am and pm on the bottle. Resident #622 had 1 opened bottle without a name, 3 open bottles labeled with the resident's first name and last initial. Resident #922 had 1 opened bottle labeled with the resident's first letter of his/her first name and the resident's last name. Resident #463 had 1 opened bottle labeled with	S3211		

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the resident's first name and am.
Resident #768 had 2 open bottles labeled with first name and last initial. Also, within the upper cabinets were 1 opened OTC medications without a name but CMA C identified as the residents and a tube of arthritic cream with the resident's initials.
Resident #660 had an open bottle labeled with the first name and in the upper cabinet 1 open bottle labeled with the resident's initials and 2 open bottles of OTC medication labeled with the resident's first name and last initial which CMA C reported a staff member had found the medications in the resident's room for which the resident did not have a medical care provider's order and the family planned to take the medications home. However, these medications were stored in the same area and medications for the resident who did have active orders and could be administered inadvertently.
Resident #879 had an open bottle with the first name and a partially used box of Alka-Seltzer cold plus with the first name only on the box.

In the upper cabinetry of the medication were various medications which CMA C identified as overflow medications for the resident.
In a plastic bin within the upper cabinet labeled for resident #687 observation revealed a small clear plastic zip sealed type bag which contained a tube of OTC bacitracin, gauze and bandages. The tube of bacitracin was not labeled, and the small bag had some writing which was rubbed off and illegible. The plastic bin also had a bottle of OTC medication without a name and CMA C reported finding the medication in the resident's room last week.

The upper cabinetry also had 2 open bottles of Geri-tussin (cough syrup) with the word "Stock"

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S3211	Continued From page 12 written on it. CMA C explained the medication could be used for any resident who had an order and had not gotten the medication yet. Observation of the far-left upper cabinet revealed various OTC medications and CMA C reported the medications were charged out by the bottle/container to the resident. Observation revealed the following open OTC medications without a specific resident name: A box of antidiarrhea medication which had 20 of 24 tablets A bottle of fish oil 1,000 milligram (mg) soft gels A bottle of gentle laxative 5 mg A container of clear-lax A bottle of cranberry juice 425 mg tablets A bottle of vitamin D 10 microgram tablets Interview on 6/26/19 at 9:26 AM with CMA C revealed he/she would write the first name and last initial of the resident when the resident and/or family brought in OTC medications and place the bottles in the medication drawers. Interview on 6/26/19 at 10:35 AM with licensed nurse D revealed he/she expected the CMAs to write the resident's name or initials on the OTC bottles which the resident or family brought in. He/she reported the facility maintained some OTC medications to have available for residents and the staff should charge the whole bottle to the resident and place the bottle in the resident's med drawer. He/she reported the facility should not have medications to be used as "Stock". The administrator/operator failed to ensure a licensed nurse or licensed pharmacist labeled over-the-counter medications with the resident's full name.	S3211		

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S3215	Continued From page 13	S3215		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by:	S3215		

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BROOKSIDE RETIREMENT COMMUNITY ASSISTED L	702 W 7TH PO BOX 308 OVERBROOK, KS 66524

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S3215	Continued From page 14 KAR 26-41-205 (h)(1) The facility reported a census of 17 residents and the facility managed medications for 14 of those residents. Based on observation and interview the administrator/operator failed to ensure licensed nurses or medications aides stored controlled medications managed by the facility in a separately locked compartment within a locked medication room, cabinet or medication cart for residents (#312, #463, #660 and #687). Findings included: - The resident roster provided on 6/26/19 indicated the facility managed the medications/treatments for residents #312, #463, #660 and #687. On 6/26/19 at 9:26 AM certified medication aide (CMA) C opened the locked medication room door and indicated the cabinetry within held all the resident's medications. Observation revealed none of the medication drawers were locked. Medication storage observation revealed the cabinetry drawers also contained controlled substances for 4 residents (#312, #463, #660 and #687). Resident #312 had 3 cassettes (am, pm and HS [hours of sleep]) of Diazepam (an anxiolytic and sedative) 10 milligrams (mg) tablets. Resident #463 had 2 cassettes (am and HS) of Lorazepam (sedative) 0.5 mg tablets and 2 cassettes (am and pm) of Norco (opioid and pain reliever) 10 mg tablets. Resident #660 had 1 cassette (am) of Adderall ER/amphetamine (stimulant) 10 mg tablets and 1	S3215		

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S3215	Continued From page 15 cassette of alprazolam (sedative) 0.25 mg for PRN (as needed) use. Resident #687 had a pill bottle of Norco 5 mg tablets. Interview on 6/26/19 at 10:30 AM with CMA C confirmed the medication drawers were to be locked and he/she had not locked them after the morning medication pass. Interview on 6/26/19 at 10:35 AM with licensed nurse D and administrator/operator E confirmed an expectation for the medication drawers to be locked in addition to the medication room door for the separately locked area for controlled substances. The facility's policy/procedure titled Medication Management directed staff to store controlled medications managed by the facility in a separately locked compartment within a locked medication room, cabinet or medication cart. The administrator/operator failed to ensure licensed nurses or medications aides stored controlled medications managed by the facility in a separately locked compartment within a locked medication room, cabinet or medication cart for residents (#312, #463, #660 and #687).	S3215		
S3225 SS=E	26-41-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the facility and each time the resident experiences any significant	S3225		

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S3225	Continued From page 16 change in condition. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l) The facility reported a census of 17 residents. The sample included 3 residents. Based on record review and interview the administrator/operator failed to ensure a licensed pharmacist conducted a medication regimen review for 3 of 3 sampled residents (#768, #879 and #922) at least quarterly whose medication were managed by the facility. Findings included: - Record review for resident #768 revealed an annual functional capacity screen dated 4/08/19 which indicated the resident needed physical assistance with medications and treatments. Review of the negotiated service agreement dated 4/08/19 revealed the facility staff managed and administered the resident's medications. Review of the resident's record on 6/26/19 at 1:30 PM revealed no evidence of a medication regimen review by a licensed pharmacist between 2//05/18 (last survey) and 6/26/19.	S3225		

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S3225	Continued From page 17 On 6/26/19 at 2:28 PM licensed nurse D reported he/she found a pharmacy review for the resident completed on 3/27/19 which had inadvertently been placed in a drawer and not processed. He/she provided evidence of a review conducted in September 2018. The administrator/operator failed to ensure a licensed pharmacist conducted a medication regimen review for this resident whom the facility managed medications at least quarterly. - Record review for resident #879 revealed the annual functional capacity screen dated 6/18/2019 and the significant change FCS dated 7/12/18 indicated the resident needed physical assistance with medication and treatments. The negotiated service agreement dated 7/12/18 and 6/18/19 both directed facility staff to administer all resident medications and treatments. Review of the resident's record on 6/26/19 at 12:50 PM revealed 1 scanned document of a pharmacy review on 9/28/18 and 1 on 2/7/19. On 6/26/19 at 2:28 PM licensed nurse D reported he/she found a pharmacy review for the resident completed on 3/27/19 which had inadvertently been placed in a drawer and not processed. The administrator/operator failed to ensure a licensed pharmacist conducted a medication regimen review for this resident whom the facility managed medications at least quarterly. - Record review for resident #922 revealed the annual/significant change functional capacity screen dated 5/020/19 indicated the resident	S3225		

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S3225	Continued From page 18 needed physical assistance with medication and treatments. The negotiated service agreement dated 5/02/19 directed facility staff to administer all medications and treatments. Record review of the electronic resident record on 6/26/19 at 11:30 AM revealed no evidence of a licensed pharmacist drug regimen review. On 6/26/19 at 2:28 PM licensed nurse D reported he/she found a pharmacy review for the resident completed on 3/27/19 which had inadvertently been placed in a drawer and not processed. He/she provided evidence of a review conducted in September 2018 and December 2018. The administrator/operator failed to ensure a licensed pharmacist conducted a medication regimen review for this resident whom the facility managed medications at least quarterly.	S3225		
S3265 SS=F	26-41-104 (a) Disaster and Emergency Preparedness (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104 (a)	S3265		

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S3265	Continued From page 19	S3265		

The facility reported a census of 17 residents. The facility reported 5 of the 17 residents had cognitive impairment. Based on record review and interview the administrator/operator failed to conduct an emergency evacuation drill with the least amount of staff on duty to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location.

Findings included:

- On 6/26/19 licensed nurse D provided the resident roster which identified 5 residents with cognitive impairment. He/she reported staffing the facility with 1 certified staff member in the evening and overnight.

On 6/26/19 at 2:45 PM administrator/operator E provided documentation for the annual evacuation of the facility conducted on 5/10/19 at 12:15 PM and 6/29/18 at 9:55 AM.

The 5/10/19 monthly fire drill report indicated the time of the drill was 12:15 PM. The report indicated a fire drill was done during a routine sprinkler system check and all personnel was asked to evacuate the building which took 5 minutes. The documentation did not include information about how many staff were used to practice the evacuation to ensure residents could be evacuated safely with the least amount of staff which would be on duty. The documentation did not indicate where the residents were evacuated to, how did the residents evacuate (ambulatory, by wheelchair and if assisted by staff) and if a staff member stayed with the cognitively impaired residents during the practice evacuation.

The 6/29/18 monthly fire drill report indicated the

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S3265	Continued From page 20 time of the drill was 9:55 AM and indicated a staff member pulled the fire alarm with an audible alarm. The documentation indicated all residents and visitors were evacuated in 2.5 minutes but failed to indicate how many staff participated in the evacuation to ensure the least amount of staff on duty could safely evacuate the residents in that time frame. The documentation did not indicate where the residents were evacuated to, how did the residents evacuate (ambulatory, by wheelchair and if assisted by staff) and if a staff member stayed with the cognitively impaired residents during the practice evacuation Interview on 6/26/19 at 3: 40 PM with administrator/operator E confirmed the documents lacked evidence of how many staff participated in the evacuation for 2018 and 2019, lacked where the residents were evacuated to, how did the residents evacuate (ambulatory, by wheelchair and if assisted by staff) and if a staff member stayed with the cognitively impaired residents during the practice evacuation The administrator/operator failed to conduct an emergency evacuation drill with the least amount of staff on duty to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location.	S3265		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency	S3280		

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S3280	Continued From page 21 management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104 (d) (3) The facility reported a census of 17 residents. Based on interview and record review the administrator/operator failed to ensure staff had disaster and emergency preparedness by a failure to conduct a quarterly review of the facility's emergency management plan. Findings included: - On 6/26/19 during the entrance conference at 10:30 AM the surveyor requested the documentation for training/review of the facility's emergency management plan with residents and staff conducted every quarter for the since the last survey conducted on 2/05/18. On 6/26/19 at 3:20 PM licensed nurse D provided documentation of the quarterly residents' review of the emergency management plan and none for the staff.	S3280		

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S3280	Continued From page 22 On 6/26/19 at 4:00 PM administrator/operator E provided a sheet of paper titled " Pay Notes" and dated 4/01/19 which listed some information regarding a request for volunteers, a thank you for picking up shifts, information about scheduling changes, "Review of Emergency Preparedness Plan in both manor and assisted living, information regarding reliance standard health insurance and a final thank you to staff for all they do. The documentation did not indicate the facility provided and ensured staff reviewed the policy and procedures for emergency preparedness. An additional 2 pages were provided of staff signatures titled, "Payroll check sign off" and dated 4/02/19. Administrator/operator E indicated the signature pages were for when staff picked up the paychecks and were given the "Pay Notes". Review of the undated facility policy/procedures titled, Disaster and Emergency Preparedness directed each administrator/operator to ensure disaster and emergency preparedness by ensuring the performance of a quarterly review of the facility's emergency management plan with employees and residents. The administrator/operator failed to ensure staff had disaster and emergency preparedness by a failure to provide information for a quarterly review on the facility's emergency management plan.	S3280		