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	N078017	A. BUILDING: _____ B. WING _____	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named assisted living facility conducted on 7/02/19, 7/03/19, 7/08/19 and 7/09/19.	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) The facility reported a census of 12 residents. The sample included 3 residents and 1 focused review. Based on record review and interview the operator failed to ensure the negotiated service agreement included services provided by an outside source and the party responsible for payment of the outside services for 2 of 3	S3085		

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

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sampled residents #272 and #309 regarding therapy services.

Findings included:

- On 7/02/19 licensed nurse D provided a resident roster which indicated no residents received outside services. After a discussion about what classified as outside services licensed nurse D made changes to the resident roster which still did not reflect any residents who received therapy services.

Record review for resident #272 revealed an admission date of 12/06/17 with diagnoses of hypertension, diabetes mellitus type 2, cardiomyopathy, atrial fibrillation, congestive heart failure, edema, vitamin B-12 deficiency, long-term use of aspirin and hypercholesterolemia.

The annual functional capacity screen (FCS) dated 6/13/19 identified the resident with intact cognition and independent with all activities of daily living.

The negotiated service agreement/health service plan (NSA/HSP) dated 6/13/19 indicated the resident would receive skilled nursing services of vital sign monitoring of a daily blood pressure and 3 meals a day. Under other services/needs were glasses, dentures, PRN (as needed) physical therapy, PRN lab work and podiatry services. The NSA/HSP included a blanket statement of the resident's responsibility to cover the costs of these services and the provider of the service would bill the source of reimbursement if the resident had insurance coverage available, Medicare, Medicaid or private insurance.

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S3085	Continued From page 2 Review of the nursing notes revealed on 6/18/19 at 12:10 PM the resident's medical care provider was contacted on the resident's request to have physical therapy for chronic back pain. An entry at 10:07 PM indicated the medical care provided gave an order for physical therapy to evaluate and treat. Review of physical therapy plan for treatment notes dated 6/21/19 indicated the resident would begin treatment 3 times a week for 6 weeks to decrease pain and increase abilities to perform desired activities. Interview with licensed nurse D on 7/02/19 at 4:30 PM confirmed the resident received a physical therapy evaluation with a plan for treatment. He/she confirmed the NSA/HSP was not amended with signatures of the resident and/or responsible party to indicate these services were starting and who was responsible for payment. The administrator/operator failed to ensure the negotiated service agreement included services provided by an outside source and the party responsible for payment of the outside services regarding therapy services for this resident. - On 7/02/19 licensed nurse D provided a resident roster which indicated no residents received outside services. After a discussion about what classified as outside services licensed nurse D made changes to the resident roster which still did not reflect any residents who received therapy services. Record review for resident #309 revealed an admission date of 2/12/16 with diagnoses of kidney failure, open-angle glaucoma, hypocalcemia and long-term use of aspirin.	S3085		

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S3085	Continued From page 3 The annual functional capacity screen dated 6/14/19 identified the resident with short-term memory deficit and impaired decision making. He/she needed complete assistance with bathing and physical assistance with dressing, toileting and transfers. He/she was unable to manage his/her own medications. The negotiated service agreement/health service plan (NSA/HSP) dated 6/14/19 indicated the facility would provide 3 meals a day, monthly and PRN (as needed) skin assessments, supervised personal care and management of medications. Under other services/needs were glasses, podiatry services, PRN physical therapy and PRN lab work. The NSA/HSP included a blanket statement of the resident's responsibility to cover the costs of these services and the provider of the service would bill the source of reimbursement if the resident had insurance coverage available, Medicare, Medicaid or private insurance. Record review revealed the resident was seen by the medical care provider on 6/27/19 with orders for physical therapy to evaluate and treat. Interview with licensed nurse D on 7/03/19 at 10:30 AM confirmed the resident received a physical therapy evaluation with a plan for treatment. He/she confirmed the NSA/HSP was not amended with signatures of the resident and/or responsible party to indicate these services were starting and who was responsible for payment. The administrator/operator failed to ensure the negotiated service agreement included services provided by an outside source and the party	S3085		

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S3085	Continued From page 4 responsible for payment of the outside services regarding therapy services for this resident.	S3085		
S3155 SS=E	26-41-204 (a) Health Care Services . (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. This REQUIREMENT is not met as evidenced by: KAR 26-41 204 (a) The facility reported a census of 12 residents. The sample included 3 residents and 1 focused review. 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 3 of 4 sampled residents (#309, #346 and #411) related to a lack of reviewing falls for causal factors and developing interventions to reduce the risk for further falls, the use of bed assistive devices/rails, inappropriate behaviors, potential risk for increased safety needs based on altering cognition, cognition deficit needs, transfer assistance, toileting and personal hygiene needs. Findings included:	S3155		

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S3155	Continued From page 5 - Record review for resident #411 revealed an admission date of 11/15/18 with diagnoses of dementia without behavioral disturbances, generalized anxiety, idiopathic peripheral neuropathy (unknown cause of peripheral nerve damage) and hypothyroidism. The admission functional capacity screen dated 11/15/18 indicated the resident had short-term memory deficit, impaired memory recall and decision making. He/she needed physical assistance with bathing, dressing and supervision with toileting and mobility. He/she was marked as a fall risk and used an assistive device (cane, walker, crutches) but did not identify the use of a bed assistive device. The record included an elopement risk assessment which identified the resident as a new admission, voiced wanting to leave, independent with mobility and was forgetful/short attention span. The assessment failed to include the resident used medications for his/her dementia and generalized anxiety which increased his/her risk score. The fall risk assessment dated 11/15/18 indicated the resident had a moderate risk for falling. Record review revealed no assessment related to the use of a bed assist device, 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.	S3155		

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S3155	Continued From page 6 Review of the negotiated service agreement/health service plan (NSA/HSP) dated 11/15/18 revealed the facility would provided skilled nursing services of assessments as needed and supervised nursing services of personal care and medication management. The NSA/HSP did not address the resident impaired cognition needs, safety risk related to varying cognition, fall risk or inappropriate behaviors (recorded in the nursing notes). The NSA/HSP indicated the resident used his/her own cane but failed to include the use of a bed assist device. Review of the nursing notes revealed the following entries regarding the resident's confusion, leaving the facility without staff's knowledge and inappropriate behaviors: On 11/15/18 at 4:50 PM - regarding admission - he/she came to assisted living because he/she needed more assist with activities of daily living and supervision due to some memory problems. He/she does have some short-term memory problems and does have problems driving and admitted to getting lost a few times while driving alone, so he/she planned to stop driving at this time. He/she used a cane for ambulation with unsteadiness due to diagnosis of cryptogenic sensory neuropathy with sensory ataxia (chronic sensory deficit). Medication orders received for citalopram (an selective serotonin reuptake inhibitor - used to treat anxiety) and memantine (treatment of dementia). On 11/17/18 at 9:12 AM - resident walked to the long term care facility looking for a friend and got lost when he/she was ready to return to the Assisted Living facility. The resident then called the facility number upset and yelling because he/she did not have 2 folding chairs available to use. Resident given folding chairs as requested. On 11/30/19 at 11:40 AM - staff report having to	S3155		

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continue to cue and guide resident for direction to room or dining room daily. Resident would wander in back hall by laundry room or whirlpool room looking for friend who lives on the main side (long term care) - cooperative with redirection.
On 2/11/19 at 2:33 PM - resident noted to have an appointment this day with a dermatologist in Wichita. When van driver approached resident to obtain details on address and time the resident did not remember where the appointment was or why it was made. Upon calling the office, it was discovered the appointment was made by the resident back in January and he/she was just going to be worked in.
On 2/12/19 at 8:47 AM - Behavior note - On 2/11/19 received a call from the facility van driver who reported the resident was refusing to get back on the van to come back from appointment and was angry the van would not take him/her to Kingman. The charge nurse spoke with the resident in an attempt to calm him/her down and the resident remained upset stating, "I have an appointment with [name] in Kingman and I am not coming back to the facility!" After several minutes of discussion with the nurse the resident agreed to return to the facility and then go to the appointment.
On 2/13/19 at 11:53 AM - Health status note - about the resident's behavior and argumentative state regarding companion's health care needs...
On 3/07/19 at 10:11 PM - Behavior note - the resident was standing at the medication room door talking with certified medication aide (CMA) C. The resident was agitated and rude to staff when talking about which pharmacy his/her medications should come from. He/she was concerned about his/her companion not feeling well... the nurse checked the record for the companion and attempted to explain to the resident there were not an antibiotic ordered and

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the resident responded, "Dr [name] can go to hell, the orders came from the hospital and he/she had nothing to do with it"... the resident walked away talking to him/herself, turned around and started walking towards his/her apartment and said to licensed nurse D "don't smile about it". When licensed nurse D informed the resident he/she wasn't smiling about it the resident said, "Good and don't smile at me either." The resident went back to his/her apartment talking on his/her phone.
On 3/08/19 at 2:15 AM - Behavior note - resident insisted that an emergency antibiotic script for his/her companion came from Hutchinson and the facility should have the medicine. When attempted to educate the resident that the pharmacy needed a prescription from the medical care provider to fill a medication the resident insisted the pharmacy did not need a script from the medical care provider to fill a med...
On 4/02/19 at 11:08 PM - Behavior note - the resident's companion used the call pendant for assistance and when staff responded the companion's call pendant would not reset. Resident #411 became upset and yelled "you want to take them so we can't call, it's your damn job", he/she threw the pendant towards the nurse....
On 4/29/19 at 8:56 PM - Behavior note - staff was notified around "11815" (unknown time) that the resident had left the facility in his/her car but had not reported to any staff that he/she was leaving or where he/she went. Upon further investigation... the resident got up from the dining table and said, "I got to go"... later, when staff took a room tray to the resident's companion/roommate he/she said the resident had left but he/she did not know where the resident went. A few minutes later the companion reported the resident went to Kingman for a

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concert of one of the "kids". The resident's family member was contacted who reported there were no concerts for any of the resident's grandkids that night. The family member drove around town and did not locate the resident or his/her car and his/her cell phone was off.... the resident had showed up in Kingman but the family had no idea he/she was coming and 1 family member drove the resident back while the other drove the resident's car. Review of the sign out sheet revealed no entries by this resident on this date.
On 5/02/19 at 12:00 PM - Behavior note - resident became angry at the nurse while in the apartment speaking with his/her roommate ...
On 6/06/19 at 4:27 PM - Behavior note - facility received notification from Reno county sheriff that the resident had been down in the Norwich area, had stopped at a house and asked them how to get back to Pretty Prairie... The facility contacted the resident who indicated he/she was on highway 54 heading back to the facility.
Review of the resident sign-out book revealed an entry with the resident's name and what appeared as Km & P something but was illegible with a time of 8:00 AM.

Observation on 7/03/19 at 10:30 AM revealed the resident was up and ambulatory without any assistive device in his/her room. He/she was stand-offish towards the surveyor when the surveyor went to the room to visit with the resident's roommate/companion. He/she then left the room. Observation revealed an upside down U-shaped bed assist device on the side of the bed used by the resident. When firmly pulled it remained in place between the mattress and the box spring. The gap between the 2 bars was greater than 18 inches.

Interview on 7/03/19 at 12:15 PM with licensed

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S3155	Continued From page 10 nurse D confirmed the only elopement risk assessment completed was done at the time of admission on 11/15/18 and did not reflect the medications the resident received which had an impact on his/her score and potential risk. He/she confirmed no reassessment of elopement risk was completed following episodes of leaving and not signing out or letting staff know on 4/29/19. He/she confirmed the resident had varying cognition which increased his/her safety risks. He/she confirmed the record had no assessment for the use of a bed assist device and the resident did have a device attached to the bed. He/she confirmed the NSA/HSP did not have any interventions to address the resident's cognition needs, fall risk, potential for elopement risk and the use of a bed assist device. 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 Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. The administrator/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 varying cognition needs, safety risk, fall risk, behavioral needs and use of a bed assist device.	S3155		

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S3155	Continued From page 11 - Record review for resident #346 revealed an admission date of 12/08/18 with diagnoses of congestive heart failure, angina pectoris, vertigo, diabetes mellitus type 2, hypertension, atrial fibrillation, vertigo, major depressive disorder and hypothyroidism. The admission functional capacity screen (FCS) dated 12/05/18 indicated the resident had short-term memory deficit and impaired decision making. He/she needed physical assistance with bathing and supervision for dressing, toileting, walking and transfers. He/she was unable to administer his/her own medications and treatments. He/she was at risk for fall, used an assistive device and had impaired vision. The FCS did not identify the use of a bed assistive device. 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 negotiated service agreement/health service plan (NSA/HSP) dated 12/05/18 indicated the facility would provide 3 meals daily with snack available, skilled nurse services of monthly and PRN (as needed) skin assessment and diabetic monitoring. The facility would manage the resident's medications. The NSA/HSP did not identify what diabetic monitoring included, who would perform the diabetic testing as ordered by a medical care provider and who would	S3155		

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administer the resident's insulin. Assistance with personal care was not marked but the facility would provide ambulation/transfer assistance and assistance to bath 3 times a week. The NSA/HSP indicated the resident used his/her own cane but failed to identify the use of a bed assistive device. The NSA/HSP indicated the facility staff would take a daily blood pressure and monthly weight monitoring. The NSA/HSP did not address the resident's identified fall risk or have interventions to reduce the risk of further falls.

Review of the nursing notes revealed on 4/11/19 at 3:12 AM the resident reported sitting down on the toilet and lost his/her balance hitting the right side of his/her head on the grab bar.... He/she had significant swelling , a white/black area on the right ear, a skin tear on the right forearm 6 cm (centimeters) by 7 cm, a hard hemoatoma of 11 cm above the right lateral knee and he/she complained of a headache, chills and nausea... Staff sent the resident to the emergency room (ER) for evaluation. On 4/11/19 at 8:14 AM returned to facility with negative X-rays from fall and orders to apply ice as needed to ear, obtain a clean catch urine specimen and other lab orders. Subsequent notes failed to have any information related to causal factors of the fall and interventions to reduce the risk of further falls.
On 4/19/19 at 4:02 PM the resident reported to staff that while he/she was out of the facility he/she fell walking up the curb losing his/her balance. Assessment done and noted a bandage on the right elbow which he/she bandaged while out. He/she had bruising to the right buttocks/hip area.
On 4/21/19 at 4:39 AM a health status note indicated the resident was still on fall follow-up monitoring and was observed to have difficulty with balance while holding onto the kitchen sink in

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his/her apartment. He/she was able to remain standing without assist. He/she had an increase in medication isosorbide (for chest pain) and a decrease in levemir (insulin) with no adverse reactions observed or reported.
On 4/21/19 at 9:08 AM - ... resident observed with unsteady gait with ambulation in his/her room.
On 4/22/19 at 10:28 AM - fall investigation indicated the resident used a single point cane intermittently and was educated/trained on it's use. He/she stated he/she tripped over the curb as the cause of the fall. Continue with education regarding proper cane usage.

The notes between 3/03/19 and 7/02/19 revealed multiple illness, hospitalizations, alterations in cognition, increased need for physical assistance with activities of daily living (ADL), physical therapy ordered and discontinued due to non-compliance with appointments. The NSA/HSP failed to reflect the resident's varying cognition, ADL assistance needs, the period of time he/she received physical therapy and his/her fall risk/history of falls.

Nursing note dated 7/01/19 at 9:54 AM indicated staff entered the resident's room around 9:25 AM and found the resident seated on the floor with his/her back against the air conditioner unit. He/she reported remembering that he/she had sat on the edge of the bed, stood up to go to the restroom and then he/she was on the floor. He/she had a skin tear to the outside of his/her right wrist which was cleaned and bandage applied. He/she had received a narcotic pain medication at 9:00 AM, his/her walker was outside of the room in the hallway and his/her cane was over by his/her chair against the wall. Subsequent notes failed to have any information related to causal factors of the fall and

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	N078017	A. BUILDING: _____ B. WING _____	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

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S3155	Continued From page 14 interventions to reduce the risk of further falls. The NSA/HSP lacked a revision/amendment for interventions to reduce the risk of further falls. Observation on 7/03/19 at 8:45 AM revealed the resident ambulated about the dining room area with a 3 wheeled walker. At 10:30 AM observation revealed he/she ambulated about his/her apartment without the use of an assistive device and merely held onto items about the room. On his/her side of the bed was an upside down U-shaped bed assistive device which was not attached firmly to the bed and freely moved from between the mattress and the box spring with light pressure. The gap between the 2 bars was about 10 inches. Interview with the resident on 7/03/19 at 10:30 AM revealed he/she had fallen just before the foot of the bed. He/she said, he/she must have tripped over his/her own feet. He/she indicated bandages on his/her left forearm of skin tears. Interview on 7/03/19 at 10:45 AM with licensed nurse D confirmed he/she had not completed an assessment of the bed assist device. He/she confirmed the NSA/HSP did not address the resident's fall risk or interventions to reduce fall risks, failed to include the bed assist device in use, the resident's varying cognition and varying ADL needs. 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	S3155		

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S3155	Continued From page 15 Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. The administrator/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. - Record review for resident #309 revealed an admission date of 2/12/16 with diagnoses of kidney failure, open-angle glaucoma, hypocalcemia and long-term use of aspirin. The annual functional capacity screen dated 6/14/19 identified the resident with short-term memory deficit and impaired decision making. He/she needed complete assistance with bathing and physical assistance with dressing, toileting, transfers and used an assistive device for walking. He/she was frequently incontinent of his/her bladder and was unable to manage his/her own medications. The negotiated service agreement/health service plan (NSA/HSP) dated 6/14/19 indicated the facility would provide 3 meals a day, monthly and PRN (as needed) skin assessments, supervised personal care and management of medications. The NSA/HSP did not indicate who would manage the resident's treatments and/or the resident's ongoing skin condition with specific needs/cares. Personal care included bathing assistance 3 times a week but did not specify what that included, ambulation/transfer	S3155		

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S3155	Continued From page 16	S3155		

assistance was marked with PRN and transfer assist circled without any specifics, personal hygiene was marked as "if incontinent" but did not specify any toileting needs and under needs/preferences was written ensure clean undergarments in AM. Under other services/needs were glasses, used his/her own walker, podiatry services, PRN physical therapy, PRN lab work, daily blood pressure checks with medication pass, weekly weight monitoring and other was checked without an specifics of what other meant.

Licensed nurse D on 7/03/19 provided a task list report which included the electronic portion of what direct care staff had access to for the resident's activities of daily living needs. The task list report did not have specifics for the resident's cognitive needs and merely said cognitive activities PRN, bladder continence included PRN and no specifics for assistance with incontinence needs, personal care included both 15 minutes and PRN without specifics, assist with changing undergarments day/evening, transferring and dressing day/evening/nights PRN without any specifics and shower assistance in AM before church but did not specify the specifics of assistance needs to include whether the resident completed any portion or if staff provided total assistance.

Review of the nursing notes revealed the following:
On 3/07/19 and 3/08/19 entries about redness/rash under abdominal fold and chest area.
On 4/11/19 at 2:43 PM - resident noted with increased confusion during the night hours, ambulated out of his/her room inappropriately dressed which required cueing and assistance to

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S3155	Continued From page 17 change garments. On 6/12/19 at 10:30 AM - certified medication aide (CMA) G observed the resident at around 7:00 AM asleep on the toilet with no report from night shift of the resident being up. At 10:00 AM the resident was observed by certified staff H on the toilet and the resident was unable to get up without a 2 person assist. The resident complained of right side pain. Interview on 7/03/19 at 9:50 AM with CMA J reported the resident needed assistance to use the toilet and was prompted to go to the restroom about every 2 hours. He/she said staff would change the resident's incontinent brief and provided perineal care as needed. Interview on 7/03/19 at 10:45 AM with licensed nurse D confirmed the resident had specific care needs which were not indicated on the NSA/HSP of toileting, transfers, skin care and treatments. The administrator/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 skin care, treatments, bathing assistance needs, ambulation/transfers specific needs, toileting and personal hygiene needs.	S3155		
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.	S3202		

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S3202	Continued From page 18 This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) (4) The facility reported a census of 12 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 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 7/02/19 at 3:10 PM licensed nurse D reported certified medication aides (CMAs) were delegated to perform blood sugar testing for residents. Review of the personnel file for CMA B on 7/03/19 at 11:11 AM revealed he/she began employment on 12/06/18 and currently still employed. The record lacked documentation of additional training to allow this CMA to perform blood sugar testing. Review of the personnel file for CMA F revealed he/she began employment on 12/18/18 and currently still employed. The record lacked documentation of additional training to allow this CMA to perform blood sugar testing. Interview on 7/02/19 at 2:22 PM with CMA C revealed he/she performed blood sugar testing for resident's who had a medical care provider's order for them.	S3202		

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S3202	Continued From page 19 Interview on 7/03/19 at 12:43 PM with licensed nurse D confirmed all the CMAs employed by the facility were expected to perform blood sugar testing. He/she confirmed CMA B and CMA F's personnel file lacked evidence of further training/competency to allow them to perform blood sugar testing. He/she confirmed none of the CMAs had this training and documentation with only a skills fair checklist completed. The administrator/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 (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. This REQUIREMENT is not met as evidenced by:	S3211		

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S3211	Continued From page 20 KAR 26-41-205 (g) (3) The facility reported a census of 12 residents and the facility managed medications for 7 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 for 7 out 7 residents whom the facility managed his/her medications (#168, #309, #346, #411, #472, #486 and #613). Findings included: - The resident roster provided on 7/02/19 indicated the facility managed medications/treatments for 7 residents. On 7/02/19 at 2:22 PM certified medication aide (CMA) C opened the only medication cart. Observation revealed over-the-counter (OTC) medications for 7 of the 7 residents identified with facility managed medications (#168, #309, #346, #411, #472, #486 and #613). The OTC medications did not include the resident's full name and were labeled with the room number, initials, first name or not labeled at all but identified by CMA C or licensed nurse D as belonging to the resident as follows: Resident #168 had 10 opened OTC medications Resident #309 had 12 opened OTC medications Resident #346 had 14 opened OTC medications Resident #411 had 1 opened OTC medication with his/her first name and a room # which was not the # identified as the resident's room # on the resident roster. Resident #472 had 1 opened OTC medication Resident #486 had 7 opened OTC medications Resident #613 had 5 opened OTC medications	S3211		

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S3211	Continued From page 21 Also, within the cart were the following OTC medications without any identifying labeling and CMA C or licensed nurse D were not able to identify which resident they belonged to: Opened bottle of Melatonin 5 milligrams (mg) Opened bottle of Vitamin C 500 mg 2 open bottles of vitamin D3 5,000 units Unopened bottle of Cetirizine 10 mg Unopened bottle of vegetable laxative Unopened box of Areds (vitamin for the eyes) The cart also had the following open OTC medications which were labeled as "Stock" or identified by CMA C and licensed nurse D as medications given to residents who had a medical care provider's order but had not provided the medication yet: Geri-dryl (diphenhydramine) 25 mg acetaminophen capsules 500 mg Tums (antacid) Geri-mox (liquid antacid) Geri-tussin DM Natural vegetable laxative meclizine 12.5 mg Diphenhydramine 25 mg Interview on 7/02/19 at 2:21 PM with CMA C said when family or the resident brought in OTC medications he/she would write the resident's room number or name on the bottle. Interview on 7/02/19 at 2:30 PM with licensed nurse D revealed he/she expected the CMAs to write the resident's room number or name on the OTC bottles which the resident or family brought in. He/she was not aware of the labeling requirement for the OTC medications and the facility should not have medications to be used as "Stock".	S3211		

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S3211	Continued From page 22 The administrator/operator failed to ensure a licensed nurse or licensed pharmacist labeled over-the-counter medications with the resident's full name.	S3211		
S3310 SS=E	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: K.A.R 26-207 (c) The facility reported a census of 12 residents. The sample included 3 residents. Based on interview and record review for 2 newly hired/current employees and 3 out 3 residents sampled (#272, #309 and #346) the administrator/operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		

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S3310	Continued From page 23 Findings included: - Review of newly hired employee certified staff A revealed he/she began employment on 12/08/18. The employee record included a document for the first step of a 2-step tuberculosis (TB) skin test completed on 1/22/19 (45 days after he/she began providing care to residents). The facility failed to conduct a 2-step TB skin test within 7 days of employment. Certified staff B began employment on 12/21/18. The employee record included a document for the first step of a 2-step tuberculosis (TB) skin test completed on 1/14/19 (24 days after he/she began providing care to residents). The facility failed to conduct a 2-step TB skin test within 7 days of employment. Record review for resident #272 revealed an admission date of 12/06/17 the record included an annual TB skin test which documented the date the test was planted but failed to indicate the date when the test was read to ensure the test was read within 48-72 hours for accuracy. Record review for resident #346 revealed an admission date of 12/08/18 the record included a TB skin test done while the resident resided in the sister facility which documented the date the test was planted (11/20/18) but failed to indicate the date when the test was read to ensure the test was read within 48-72 hours for accuracy. Record review for resident #309 revealed an admission date of 2/12/16. The record lacked evidence of an annual review or testing for TB. On 7/03/19 at 10:00 AM a request for evidence of TB testing was made to licensed nurse D with none provided by 7/03/19 at 3:00 PM.	S3310		

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S3310	Continued From page 24 Interview on 7/03/19 at 11:11 AM with business office manager K confirmed the records for certified staff A and B indicated the testing was not done within 7 days of beginning employment. Interview on 7/03/19 at 11:00 AM with licensed nurse D confirmed the records for residents #272, #309 and #346 lacked evidence of TB screening and/or testing as required. The administrator/operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 regarding newly hired employees, newly admitted residents and annual screening for residents.	S3310		
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 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,	S3320		

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S3320	Continued From page 25 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 12 residents. The facility identified 5 of 12 residents with cognitive impairment. Based on observation and interview the administrator/operator failed to ensure staff secured all chemicals to maintain the safety of the cognitively impaired residents. Findings included: - Observation on 7/02/19 during the initial tour at 2:15 PM revealed an open concept kitchenette and dining room with no restriction on the access by residents. The kitchenette had 3 counter top sinks. The double sink had an unlocked cabinet under the sink which contained the following chemicals labeled with warning statements of keep out of reach of children, harmful or fatal if swallowed, harmful to eyes, flammable and toxic if inhaled: A full spray can of foaming disinfectant cleaner A 1/3 full spray bottle of Clorox clean-up A full spray can of stainless steel cleaner (harmful or fatal if swallowed) A partial spray can of Easy Off cleaner 1/2 full spray can of "1230" disinfectant/deodorant spray 1/2 full spray bottle of Oasis-146 quaternary ammonia sanitizer	S3320		

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S3320	Continued From page 26 Observation also revealed an unlocked cabinet under the single sink which had a spray bottle of Lysol heavy duty bathroom cleaner. The sink at the end of the counter did not have an under cabinet. Interview with licensed nurse D on 7/02/19 at 2:20 PM confirmed the chemicals in the under cabinet sink should be locked for safety. The administrator/operator failed to ensure chemicals were locked for resident, and visitor safety.	S3320		