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THE WILLOW HOUSE	2900 WILLOW STREET HAYS, KS 67601

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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 8/28/18, 8/29/18, 8/30/18 and 9/4/18.	S 000		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201 (c)(1) The facility reported a census of 4 residents. The sample included 3 residents. Based on record review and interview the operator failed to ensure designated staff conducted a functional capacity screening at least every 365 days for 1 of 3 sampled residents (412). Findings included: - Record review revealed resident #412 admitted on 8/25/16 with diagnoses of dementia, anxiety, depression, congestive heart failure, history of cerebral vascular accident (stroke), progressive weakness, falls, right foot drop and degenerative disc disease in lumbosacral region. Record review revealed a functional capacity	S5085		

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

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S5085	Continued From page 1 screen (FCS) dated 8/3/17 and no other FCS. The 8/3/17 FCS indicated the resident needed physical assistance with bathing, dressing, toileting, transfers, mobility and supervision with eating. He/she had short-term and long-term memory deficit, memory/recall deficit and impaired decision making. He/she was at risk for falls and unsteadiness and had impaired vision. Interview on 8/29/18 at 11:08 AM licensed nurse/operator F confirmed he/she failed to complete the required the annual FCS for this resident. The operator failed to ensure designated staff conducted a functional capacity screening at least every 365 days for this resident.	S5085		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus 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.	S5105		

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S5105	Continued From page 2 This REQUIREMENT is not met as evidenced by: KAR 26-42-202 (a) (1)(2)(3) The facility reported a census of 4 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to develop a written negotiated service agreement based on the resident's functional capacity screening, service needs and preferences that included a description of services the resident would receive, identification of the provider of each service and identification of each party responsible for payment if outside resources provided a service for 3 of 3 sampled residents (#407, #408 and #412). Findings included: - Record review for resident #407 revealed an admission date of 6/7/16 with diagnoses of Parkinson's, hypertension and weakness. The annual functional capacity screen (FCS) dated 11/8/17 indicated the resident was cognitively intact, required physical assistance with bathing, dressing, toileting and supervision with transfers, walking/mobility and eating. He/she was unable to safely manage his/her own medications and treatment. He/she was at risk for falls and used a walker. He/she used a wheelchair to sit at the dining room table. The NSA dated 6/7/16 recorded the facility provided 3 meals a day with snacks and assistance with eating, and the resident needed full assist 2 times a week for bathing. The NSA lacked a description of services for morning and evening cares, toileting, ambulation assistance with devices, supervised nursing services,	S5105		

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S5105	Continued From page 3	S5105		

management of medication, behavioral symptom management and personal care.

Observation on 8/28/18 at 1:20 PM revealed the resident seated in a wheelchair at the dining room table, eating independently without any adaptive devices.

Observation on 8/29/18 at 10:22 AM revealed certified medication aide (CMA) A assisted the resident with morning cares and toileting.

Observation on 8/29/18 at 12:31 PM revealed the resident ambulated independently with a wheeled walker from the living room towards his/her room.

Interview on 8/29/18 at 10:45 AM with CMA A revealed the resident needed assistance with dressing but was mostly independent with everything else and able to make his/her needs known.

On 8/29/18 at 11:52 AM licensed nurse/operator F confirmed the resident needed assistance with bathing but not full assistance, needed assistance with dressing and undressing, toileting and sometimes while walking. He/she confirmed the NSA lacked a description of the services based on the FCS and health services needed and who was responsible to provide those services.

The operator failed to develop a written negotiated service agreement for this resident based on the his/her functional capacity screening, service needs and preferences which included a description of services the resident would receive and identification of the provider of each service.

- Record review for resident #408 revealed an

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admission date of 12/1/17 with diagnoses of Parkinson's, hypertension, age related osteoporosis with history of healed osteoporosis fracture.

The admission functional capacity screen (FCS) dated 12/1/17 indicated the resident needed physical assistance with bathing, dressing, toileting, transfers with supervision needed for walking/mobility and eating. He/she was at risk for falls or unsteadiness. He/she was not able to manage his/her own medications and treatments.

The NSA dated 12/1/17 recorded the facility provided 3 meals a day with snacks but lacked a description of the supervision needed for eating, the resident would bathe 2 times a week and as needed but lacked a description of the physical assistance needed. The NSA lacked a description of services for dressing, toileting, mobility with or without assistive device, medication management, behavioral symptom management, personal care. and transfer had the typed word of "one person" circled and hand written "some time" but lacked a description of the transfer assistance the resident needed.

Observation on 8/28/18 at 3:48 PM revealed licensed nurse/operator F applied a gait belt and assisted the resident out of a personal vehicle and to walk with a wheeled walker and physical assistance on the outside ramp into the house and to a recliner in the living room.

On 8/29/18 at 11:52 AM licensed nurse/operator F confirmed the resident needed assistance with bathing, dressing and undressing, toileting and walking. He/she confirmed the NSA lacked a description of the services provided and who was

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S5105	Continued From page 5	S5105		

responsible to provide those services based on the FCS and health services needed.

The operator failed to develop a written negotiated service agreement for this resident based on the his/her functional capacity screening, service needs and preferences which included a description of services the resident would receive and identification of the provider of each service.

- Record review revealed resident #412 admitted on 8/25/16 with diagnoses of dementia, anxiety, depression, congestive heart failure, history of cerebral vascular accident (stroke), progressive weakness, falls, right foot drop and degenerative disc disease in lumbosacral region.

Record review revealed a functional capacity screen (FCS) dated 8/3/17 and no other FCS. The 8/3/17 FCS indicated the resident needed physical assistance with bathing, dressing, toileting, transfers, mobility and supervision with eating. He/she had short-term and long-term memory deficit, memory/recall deficit and impaired decision making. He/she was at risk for falls and unsteadiness and had impaired vision.

The negotiated service agreement (NSA) dated 8/25/16 recorded the facility provided 3 meals a day with snacks and assistance with eating and the resident needed full assist 2 times a week for bathing. The NSA lacked a description of services for morning and evening cares, toileting, ambulation assistance with devices, needs associated with cognitive deficit, supervised nursing services, management of medication, behavioral symptom management and personal care. The NSA indicated the resident received skilled nursing services from a preferred home

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S5105	Continued From page 6 health but did not specify who was responsible for payment or what those services included. Observation on 8/28/18 at 3:07 PM revealed licensed nurse/operator F applied a gait belt and assisted the resident to stand from a recliner in the living room and walk with a wheeled walker and physical assistance to the bathroom. On 8/29/18 at 11:52 AM licensed nurse/operator F confirmed the resident needed assistance with bathing, dressing and undressing, toileting and walking. He/she confirmed the NSA lacked a description of the services provided and who was responsible to provide those services based on the FCS and health services needed. The operator failed to develop a written negotiated service agreement for this resident based on the his/her functional capacity screening, service needs and preferences which included a description of services the resident would receive, identification of the provider of each service and identification of each party responsible for payment if outside resources provided a service.	S5105		
S5116 SS=E	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and	S5116		

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S5116	Continued From page 7 (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d) The facility reported a census of 4 residents. The sample included 3 residents. Based on record review and interview the operator failed to review and, if necessary, revise each negotiated service agreement at least once every 365 days for 2 of 3 sampled residents (#407 and #412). Findings included: - Record review for resident #407 revealed an admission date of 6/7/16 with diagnoses of Parkinson's, hypertension and weakness. The annual functional capacity screen (FCS) dated 11/8/17 indicated the resident required physical assistance with bathing, dressing, toileting and supervision with transfers, walking/mobility and eating. He/she was unable to safely manage his/her own medications and treatment. He/she was at risk for falls and used a walker. He/she used a wheelchair to sit at the dining room table. The hand-written information on page 2 included the resident has some decrease in mobility and needed a little more assistance with transfers. Review of the only negotiated service agreement (NSA) of record dated 6/7/16 revealed the facility provided 3 meals a day with snacks and	S5116		

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assistance with eating and full assist 2 times a week for bathing. The NSA lacked any information about the resident's cognitive impairment and needs associated, any information about his/her fall risk or interventions needed to reduce the risk for falls and injuries. The NSA indicated the resident received skilled services from a home care company.

Review of the nursing notes between 10/13/16 and 8/20/18 (last entry) revealed the resident experienced falls on 6/21/17, 5/10/18 and 7/15/18 without a noted review or revision of the NSA. On 9/1/17 at 4:10 PM licensed nurse/operator F wrote the resident received orders to start using a CPAP (continuous positive airway pressure) and the NSA lacked a revision with the need for these services, equipment and responsible party.

Interview on 8/29/18 at 9:45 AM with licensed nurse/operator F revealed the resident no longer received outside services and the NSA was not revised. He/she confirmed he/she had not reviewed and if necessary revised the NSA at least annually or with changes in services.

The operator failed to review and, if necessary, revise this resident's each negotiated service agreement at least once every 365 days.

- Record review revealed resident #412 admitted on 8/25/16 with diagnoses of dementia, anxiety, depression, congestive heart failure, history of cerebral vascular accident (stroke), progressive weakness, falls, right foot drop and degenerative disc disease in lumbosacral region.

Record review revealed a functional capacity screen (FCS) dated 8/3/17 and no other FCS. The 8/3/17 FCS indicated the resident needed

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physical assistance with bathing, dressing, toileting, transfers, mobility and supervision with eating. He/she had short-term and long-term memory deficit, memory/recall deficit and impaired decision making. He/she was at risk for falls and unsteadiness and had impaired vision.

Review of the only negotiated service agreement (NSA) dated 8/25/16 revealed the facility provided 3 meals a day with snacks and assistance with eating. The NSA indicated the resident needed full assist 2 times a week for bathing and lacked any information about the services needed for morning and evening cares, toileting, ambulation assistance with devices. The NSA lacked any information about the resident's cognitive impairment and needs associated, any information about his/her fall risk or interventions needed to reduce the risk for falls and injuries. The NSA indicated the resident received skilled nursing services from a preferred home health but did not specify what those services included.

Review of physician orders revealed an order dated 7/27/17 for readmission following hospitalization post emergency room visit related to a fall with possible aspiration and diagnosed with a pleural effusion.

Review of the nursing notes between 8/25/16 and 8/20/18 (last entry) revealed the resident fell on 12/21/16, 5/3/17, 7/27/17, 11/4/17 and 8/20/18 (no notes between 11/4/17 and 8/20/18). The NSA lacked a revision of services/interventions needed to reduce the resident's risk for further falls.

Interview on 8/29/18 at 11:08 AM with licensed nurse/operator F confirmed the resident no longer received outside services and the NSA was not

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S5116	Continued From page 10 revised to reflect this change. He/she confirmed the resident had falls as listed without a revision to the NSA. He/she had not reviewed the NSA at least annually as required. The operator failed to review and, if necessary, revise this resident's each negotiated service agreement at least once every 365 days.	S5116		
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus 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 26-42-204(a) The facility reported a census of 4 residents. The sample included 3 residents. Based on observation, interview and record review the licensed nurse/operator failed to provide or coordinate the provision of necessary health care services to meet the needs of each resident and in accordance with the functional capacity screening and the negotiated service agreement for 3 of 3 sampled residents (#407, #408 and #412) related to bed rail use, falls and use of a blood thinning agent.	S5155		

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S5155	Continued From page 11 Findings included: - Record review for resident #407 revealed an admission date of 6/7/16 with diagnoses of Parkinson's, hypertension and weakness. The annual functional capacity screen (FCS) dated 11/8/17 indicated the resident required physical assistance with bathing, dressing, toileting and supervision with transfers, walking/mobility and eating. He/she was unable to safely manage his/her own medications and treatment. He/she was at risk for falls and used a walker. He/she used a wheelchair to sit at the dining room table. The FCS lacked the use of bed rails. Interview on 8/28/18 at 2:45 PM with licensed nurse/operator F revealed the negotiated service agreement (NSA) and health service plan (HSP) are an all in one document. The NSA/HSP dated 6/7/16 recorded the facility provided 3 meals a day with snacks and assistance with eating, and the resident needed full assist 2 times a week for bathing. The NSA/HSP lacked a description of services for morning and evening cares, toileting and ambulation assistance with devices. The NSA/HSP lacked information about the resident's risk for falls/unsteadiness, use of assistive devices and use of bed rails. The record lacked an assessment to verify the rail was not a restraint, the resident used the rail safely and the rail design/attachment/gaps and mechanisms were safe. Review of the nursing notes between 10/13/16 and 8/20/18 (last entry) revealed the resident	S5155		

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S5155	Continued From page 12 experienced the following falls, started on CPAP (continuous positive airway pressure) and an anticoagulant (blood thinner): On 6/21/17 at 10:00 AM licensed nurse/operator F recorded while the resident was in the bathroom getting ready for the day he/she lost his/her balance and fell backward. The resident was alone at the time and staff heard a crash from another resident's room. The resident stated his/her legs gave out. He/she received a skin tear on both elbows and one on top of his/her head but denied pain. The note lacked any further causal factors or interventions implemented to reduce the resident's risk of further falls. On 9/1/17 at 4:10 PM licensed nurse/operator F wrote the resident received orders to start using a CPAP (continuous positive airway pressure) and the NSA/HSP lacked a revision with the need for these services or equipment needed. On 5/10/18 at 2:30 PM licensed nurse/operator F recorded he/she received a report of the resident fell while trying to get candy out of his/her bottom wardrobe and received a skin tear on his/her right upper elbow. The note lacked any further causal factors or interventions implemented to reduce the resident's risk of further falls. On 5/5/18 at 2:00 PM licensed nurse/operator F recorded the resident returned from a hospital stay with diagnoses of pulmonary embolism and he/she was started on Coumadin and Lovenox (both medications to thin the blood and slow clot formation). The NSA/HSP lacked revision to include the use of these medications, risk factors of these medications and emergency interventions should the resident have unusual bleeding.	S5155		

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S5155	Continued From page 13 On 7/15/18 at 6:38 PM licensed nurse/operator F recorded he/she received a phone call from certified medication aide (CMA) A to inform him/her the resident had fell and CMA A needed help to the resident up. The resident was lying on the bathroom floor. The resident reported he/she fell on his/her bottom. The note lacked any further causal factors or interventions implemented to reduce the resident's risk of further falls. Review of the August 2018 medication administration record revealed the resident continued to receive Coumadin daily. Observation on 8/28/18 at 1:26 PM revealed the resident's bed had quarter sized bed rails on both side of the bed with one in the upright position. He/she also had an oxygen concentrator and CPAP machine at the bedside. Observation on 8/29/18 at 10:22 AM revealed certified medication aide (CMA) A assisted the resident with morning cares and toileting. Observation on 8/29/18 at 12:31 PM revealed the resident ambulated independently with a wheeled walker from the living room towards his/her room. Interview on 8/29/18 at 9:45 AM with licensed nurse/operator F confirmed the resident had bed rails on the bed per his/her request. He/she confirmed the record lacked an assessment to verify the rail was not a restraint, the resident used the rail safely and the rail design/attachment/gaps and mechanisms were safe and was not included in the NSA/HSP. He/she confirmed the NSA/HSP failed to address the resident's risk factors for falls, revision with interventions to reduce further fall risks and the	S5155		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOW HOUSE	2900 WILLOW STREET HAYS, KS 67601

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S5155	Continued From page 14 use anticoagulants. The licensed nurse/operator failed to provide or coordinate the provision of necessary health care services to meet the needs of this resident and in accordance with the functional capacity screening and the negotiated service agreement related to bed rail use, falls and use of an anticoagulant. - Record review for resident #408 revealed an admission date of 12/1/17 with diagnoses of Parkinson's, hypertension, age related osteoporosis with history of healed osteoporosis fracture. The admission functional capacity screen (FCS) dated 12/1/17 indicated the resident needed physical assistance with bathing, dressing, toileting, transfers with supervision needed for walking/mobility and eating. He/she was at risk for falls or unsteadiness. He/she was not able to manage his/her own medications and treatments. Interview on 8/28/18 at 2:45 PM with licensed nurse/operator F revealed the negotiated service agreement (NSA) and health service plan (HSP) are an all in one document. The NSA/HSP dated 12/1/17 recorded the facility provided 3 meals a day with snacks but lacked a description of the supervision needed for eating, the resident would bathe 2 times a week and as needed but lacked a description of the physical assistance needed. The NSA/HSP lacked a description of services for dressing, toileting, mobility with or without assistive device, and transfer had the typed word of "one person" circled and hand written "some time" but lacked a description of the transfer assistance the resident needed. The NSA/HSP included a section on	S5155		

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current risk or recent problems with falls/unsteadiness and handwritten 11/27 (no year) fall at home - history of falls in past week. The NSA/HSP lacked any interventions to reduce the resident's risk for further falls.

Review of the nursing notes between 12/2/17 and 2/16/18 (last entry) revealed the resident experienced multiple falls as follows:

On 12/2/17 at 1:00 PM the admission notes indicated the resident's family member reported the resident could transfer him/herself, but licensed nurse/operator F observed the resident needed assistance with transfer and walking.

On 12/11/17 at 11:13 PM licensed nurse/operator F received a call from nursing staff G (did not identify certified or licensed) to report the resident had stood up from his/her recliner in the living room and walked to the kitchen counter independently. Nursing staff G was in the kitchen at the time and before he/she could get to the resident he/she began to fall, and nursing staff G helped to lower the resident to the floor. The note lacked any further causal factors or interventions implemented to reduce the resident's risk of further falls.

On 1/12/18 at 2:25 PM licensed nurse/operator F recorded the resident fell. Licensed nurse/operator F indicated he/she was in the kitchen and heard a sound. He/she found the resident on the floor between a recliner and the wall. The resident had a scrap in the center of his/her back, on the left shoulder blade and could get up independently. The note indicated the resident continued to get up without assistance, was often confused but at times thinks clearly. Staff continued to educate about using the call

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bell and will use it at times. Family member encouraged the resident to use the call light.

The NSA/HSP lacked any information about this fall or interventions to reduce further fall risks.

On 1/20/18 at 8:41 AM licensed nurse/operator F recorded he/she received a text message at 4:08 AM about staff finding the resident on the floor in his/her room. Certified medication aide (CMA) H reported the resident denied pain, had no signs/symptoms of pain and vital signs were within normal limits. CMA H reported the resident was wrapped up in his/her bed sheets. CMA H reported the resident had been delusional all-night long. Licensed nurse/operator F came to the facility that morning and assessed the resident. The note lacked any further causal factors or interventions implemented to reduce the resident's risk of further falls.

On 2/16/18 (no time recorded) licensed nurse/operator F recorded he/she received report the resident fell/slid out of his/her bed. The note lacked any further causal factors or interventions implemented to reduce the resident's risk of further falls.

Observation on 8/28/18 at 3:48 PM revealed licensed nurse/operator F applied a gait belt and assisted the resident out of a personal vehicle and to walk with a wheeled walker and physical assistance on the outside ramp into the house and to a recliner in the living room.

8/29/18 at 10:38 AM licensed nurse/operator F confirmed the resident had fallen as recorded above and he/she had not determined causal factors or revised the NSA/HSP with each fall to reduce the risk for further falls.

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S5155	Continued From page 17 The licensed nurse/operator failed to provide or coordinate the provision of necessary health care services to meet the needs of this resident and in accordance with the functional capacity screening and the negotiated service agreement related to falls. - Record review revealed resident #412 admitted on 8/25/16 with diagnoses of dementia, anxiety, depression, congestive heart failure, history of cerebral vascular accident (stroke), progressive weakness, falls, right foot drop and degenerative disc disease in lumbosacral region. The 8/3/17 FCS indicated the resident needed physical assistance with bathing, dressing, toileting, transfers, mobility and supervision with eating. He/she had short-term and long-term memory deficit, memory/recall deficit and impaired decision making. He/she was at risk for falls and unsteadiness and had impaired vision. Interview on 8/28/18 at 2:45 PM with licensed nurse/operator F revealed the negotiated service agreement (NSA) and health service plan (HSP) are an all in one document. The NSA/HSP dated 8/25/16 recorded the facility provided 3 meals a day with snacks and assistance with eating and the resident needed full assist 2 times a week for bathing. The NSA/HSP lacked a description of services for morning and evening cares, toileting, ambulation assistance with devices, needs associated with cognitive deficit, any information about his/her fall risk or interventions to reduce the risk for further falls and injuries. Review of the nursing notes between 8/25/16 and	S5155		

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S5155	Continued From page 18 8/20/18 (last entry) revealed the resident experienced the following falls: On 8/25/16 at 8:00 PM licensed nurse/operator F recorded the resident came from a hospital setting following a fall at home with fractured ribs. He/she needed assistance with bathing, dressing, toileting, transfers and mobility. On 10/5/16 at 2:00 PM licensed nurse/operator F recorded the resident saw his/her family drive up to the building. He/she stood up and attempted to walk towards where the family member was. When the family member and licensed nurse/operator F entered the room, the resident was found on his/her knees. The note lacked any further causal factors or interventions implemented to reduce the resident's risk of further falls. 12/24/16 at 12:00 PM licensed nurse J recorded he/she was told the resident fell at 11:20 AM and upon entering the facility he/she observed the resident laying on the floor in the dining room on his/her back. The resident reported having severe lower back pain, emergency medical services (EMS) were called and the resident went by EMS to the emergency room. There were no subsequent nursing notes until 5/3/17. The note lacked any further causal factors or interventions implemented to reduce the resident's risk of further falls. On 5/3/17 at 10:04 AM licensed nurse/operator F recorded he/she received a call last night about the resident falling. The resident had no signs/symptoms of pain and no injuries noted. The notification was around 9:45 PM. The note lacked any further causal factors or interventions implemented to reduce the resident's risk of	S5155		

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further falls.

On 7/27/17 at 10:45 AM licensed nurse K recorded the resident had a vomiting episode and staff assisted the resident to the bathroom. While staff prepared the bath chair for the resident the resident began to fall, and the staff was unable to grab and assisted him/her before he/she fell to the floor landing on his/her back and hitting his/her head on the floor. The resident's pupils were sluggish and complained of rib pain. Licensed nurse K called EMS and the resident was transported to the emergency room. On 7/27/17 at 3:45 PM the resident returned to the facility, alert and oriented to name, requested to lay down, denied pain and was assisted to bed by 2 staff and use of a gait belt. The note lacked any further causal factors or interventions implemented to reduce the resident's risk of further falls.

On 11/4/17 at 8:30 PM licensed nurse/operator F recorded he/she received notification around 2:30 PM that the resident fell in the bathroom. The note lacked any further causal factors or interventions implemented to reduce the resident's risk of further falls.

Observation on 8/28/18 at 3:07 PM revealed licensed nurse/operator F applied a gait belt and assisted the resident to stand from a recliner in the living room and walk with a wheeled walker and physical assistance to the bathroom.

On 8/29/18 at 11:52 AM licensed nurse/operator F confirmed the resident needed assistance with bathing, dressing and undressing, toileting and walking.

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S5155	Continued From page 20 On 8/29/18 at 11:52 AM licensed nurse/operator F confirmed the resident had fallen as recorded above and he/she had not determined causal factors or revised the NSA/HSP with each fall to reduce the risk for further falls. The licensed nurse/operator failed to provide or coordinate the provision of necessary health care services to meet the needs of this resident and in accordance with the functional capacity screening and the negotiated service agreement related to falls.	S5155		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (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 home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' 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 26-42-104(d)(1)(2)(3)	S5215		

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S5215	Continued From page 21 The facility reported a census of 4 residents. Based on interview and record review the operator failed to ensure the residents and staff had disaster and emergency preparedness by a failure to conduct a quarterly review of the facility's emergency management plan. Findings included: - During the entrance meeting on 8/28/18 at 1:45 PM with licensed nurse/operator F revealed the operator said the facility's disaster and emergency management plan could be found in the glass doored Hutch (a freestanding unit with cabinets, a display case or both on top of its bottom half which is usually drawers) located in the dining room. He/she said the plan was available to residents, staff and visitors at all times. Licensed nurse/operator provided 2 notebooks for review. One of the notebooks contained information related to monthly fire drills, sprinkler system and emergency lighting. The other notebook was titled Policy and Procedures (P/P). Review of the P/P book revealed no identification for the emergency management plan portion. Licensed nurse/operator F said there was not a specified book/plan and said the person could just flip through the pages of the P/P book as there was not that many policies. Review of the P/P book revealed on the 8th page of the book the top of the page was titled disaster plan. The P/P included multiple pages of P/P for disaster and emergency preparedness, but the pages were mixed in with other P/Ps making it difficult for resident/staff/visitors to rapidly find the information in the event of an emergency.	S5215		

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S5215	Continued From page 22 Upon request licensed nurse/operator F confirmed he/she did not have any evidence of disaster and emergency preparedness review/training for residents upon admission or quarterly. Review of the personnel files for certified medication aide (CMA) A and C, licensed nurse B, D and K revealed all had an employment checklist with 15 items pre-typed and had check marks beside some of the items. The document had no date and no signature of the staff to indicate he/she acknowledged the training. Item #3 said facility personnel policies/acknowledgement. None of the items listed included training in disaster and emergency preparedness. Upon request licensed nurse/operator F confirmed he/she failed to have evidence of disaster and emergency preparedness quarterly review with all staff to cover all 9 elements of disaster and emergency preparedness as required (fire, flood, severe weather, tornado, explosion, natural gas leak, lack of electrical or water service, missing resident and any other potential emergency situations) at least every quarter. The operator failed to ensure the residents and staff had disaster and emergency preparedness by a failure to provide information on the facility's emergency plan at the time of admission, time of employment and conduct a quarterly review of the facility's emergency management plan.	S5215		
S5225 SS=F	26-42-207 (a) (b) (1)(2)(3)(4) Infection Control a) The administrator or operator of each home	S5225		

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S5225	Continued From page 23 plus shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; This REQUIREMENT is not met as evidenced by: KAR 26-42-207(a) The facility reported a census of 4 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to implement procedures to prevent the spread of infection related to a failure to implement standard precautions, airborne precautions and contact precautions for a resident with shingles which had the potential to affect all residents and staff. Findings included: - Record review for resident #407 revealed an admission date of 6/7/16 with diagnoses of Parkinson's, hypertension and weakness. The annual functional capacity screen (FCS) dated 11/8/17 indicated the resident required	S5225		

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physical assistance with bathing, dressing and toileting.

Review of the negotiated service agreement (NSA)/health service plan (HSP) of record dated 6/7/16 revealed the facility provided full assist 2 times a week for bathing. The NSA lacked any information about the resident's cognitive impairment and personal care needs.

Record review revealed a physician's order for 8/20/18 for Famciclovir (a medication to treat Herpes Zoster) 500 milligrams by mouth 3 times a day for 7 days in response to a fax sent by licensed nurse/operator F. The fax described a rash on the resident's back (left of midline and left side at belt line), itching, pain and looked like blistered pustules.

Review of the nursing notes revealed an entry dated 8/17/18 at 8:00 PM which read "yesterday the resident had a new rash type breakout on his/her back. Today it was less than the day before. If it persists over the weekend it will be reported to the doctor." The next entry was 8/20/18 at 6:00 PM which indicated the resident started on a medication today for shingles (Herpes Zoster). The note lacked any description of the rash or any precautions taken to prevent the spread of the virus.

Interview on 8/29/18 at 9:12 AM with licensed nurse/operator F revealed the resident first presented on 8/16/18 with redness and small bumps while certified medication (CMA) A assisted him/her to dress for the day. He/she said on 8/17/18 the rash had a little more bumps and was bigger with no visible drainage then over the weekend the resident complained of the area itching. Licensed nurse/operator F reported

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caring for the resident over the weekend and the area got bigger with more bumps and 2 areas looked blister like then the areas started to scab. He/she reported notifying the physician then on Monday of the area. Licensed nurse/operator F said standard precautions were used of handwashing and glove wearing during personal cares.

Review of the CDC website https://www.cdc.gov/shingles/hcp/hc-settings.html indicated the virus that causes shingles, the varicella zoster virus, can spread from a person with active shingles to cause chickenpox in someone who had never had chickenpox or received chickenpox vaccine. The virus is spread through direct contact with fluid from the rash blisters caused by shingles. A person with active shingles can spread the virus when the rash is in the blister-phase. A person is not infectious before the blisters appear. Once the rash has developed crusts, the person is no longer infectious. Infection-control measures depend on whether the patient with herpes zoster on whether the rash is localized or disseminated (defined as appearance of lesions outside the primary or adjacent dermatomes). In all cases, standard infection-control precautions should be followed. Localized herpes zoster, then standard precautions should be followed, and lesions should be completely covered. Disseminated herpes zoster, then standard precautions plus airborne and contact precautions should be followed until lesions are dry and crusted.

Review of the facility's policy and procedures manual revealed a policy titled Infection Control with no date which included information on standard precautions to prevent the spread of blood-borne pathogens, hand washing,

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S5225	Continued From page 26 laundering and proper handling of soiled and clean linens but nothing specific to Shingles. The policy and procedure manual contained a policy on standard precautions but nothing for air borne or contact precautions. The operator failed to implement procedures to prevent the spread of infection related to a failure to implement standard precautions, airborne precautions and contact precautions for a resident with shingles which had the potential to affect all residents and staff.	S5225		
S5246 SS=E	26-42-105 (c) Resident Record Safeguards (c) Each administrator or operator shall ensure the safeguarding of resident records against the following: (1) Loss; (2) destruction; (3) fire; (4) theft; and (5) unauthorized use. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(c) The facility reported a census of 4 residents. Based on observation and interview the operator failed to safeguard the residents' records against unauthorized use (#407, #408, #412 and #413). Findings included: - During the entrance conference on 8/28/18 at 1:20 PM licensed nurse/operator F reported the resident's records were kept in a glass doored Hutch (a freestanding unit with cabinets, a display	S5246		

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S5246	Continued From page 27 case or both on top of it's bottom half which is usually drawers) in the dining room. Observation on 8/28/18 at 2:40 PM revealed the upper cabinets of the Hutch located in the dining room were not locked and contained the charts of resident #407, #408, #412 and #413. Interview on 8/28/18 at 2:45 PM with licensed nurse/operator F confirmed the doors on the Hutch did not lock. He/she reported visitors have access to the cabinet because the survey results, policy and procedures are kept in the same area of the Hutch. The operator failed to safeguard the residents' records against unauthorized use.	S5246		
S5251 SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105 (f) (11) The facility reported a census of 4 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to ensure the documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the	S5251		

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actions for 3 of 3 sampled residents (#407, #408 and #412).

Findings included:

- Record review for resident #407 revealed an admission date of 6/7/16 with diagnoses of Parkinson's, hypertension and weakness.

The annual functional capacity screen (FCS) dated 11/8/17 indicated the resident was cognitively intact, required physical assistance with bathing, dressing, toileting and supervision with transfers, walking/mobility and eating. He/she was unable to safely manage his/her own medications and treatment. He/she was at risk for falls and used a walker. He/she used a wheelchair to sit at the dining room table.

The NSA dated 6/7/16 recorded the facility provided 3 meals a day with snacks and assistance with eating, and the resident needed full assist 2 times a week for bathing. The NSA lacked a description of services for morning and evening cares, toileting, ambulation assistance with devices, supervised nursing services, management of medication, behavioral symptom management and personal care.

Review of the physician's orders revealed on 3/3/17 the resident had 3 teeth extracted with directions to monitor for bleeding, pain and swelling. Review of the nursing notes between 10/15/16 and 8/20/18 (last entry) revealed the notes went from 10/15/16 to 6/21/17 with no notes about the teeth extraction, how the resident tolerated the procedure, monitoring for bleeding, pain and swelling.

A physician visit on 4/6/17 identified the resident

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as very weak, unable to walk or get up/down by self, stated at times had burning, frequency and discomfort when urinating. The physician ordered an antibiotic, a steroid medication, a medication for cough/congestion, medication for respiratory treatments and straight catheterize for a urine specimen. Review of the nursing notes between 10/15/16 and 8/20/18 (last entry) revealed the notes went from 10/15/16 to 6/21/17 with no notes about the resident's acute illness, symptoms, actions taken or results of those actions.

A fax to the physician dated 2/12/18 identified the resident had cold like symptoms and the physician order a medication to loosen, thin secretions and help with expectoration. Review of the nursing notes between 10/15/16 and 8/20/18 (last entry) revealed the notes went from 9/1/17 to 5/2/18 and lacked notes about the resident's acute illness, symptoms, actions taken or results of those actions.

A fax to the physician dated 4/6/18 identified the resident complained of burning and painful urination with increase urgency and staff noted increased confusion. The physician ordered a urinalysis with culture and sensitivity if indicated. Review of the nursing notes between 10/15/16 and 8/20/18 (last entry) revealed the notes went from 9/1/17 to 5/2/18 and lacked notes about the resident's acute illness, symptoms, actions taken or results of those actions.

A fax to the physician dated 8/20/18 identified the resident with a rash on his/her back to the left of midline, left side and belt line. He/she reported itching, pain and had the appearance of blistered pustules. The physician ordered Famciclovir 500 milligrams by mouth 3 times a day for 7 days.

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S5251	Continued From page 30 Review of the nursing notes between 10/15/16 and 8/20/18 (last entry) revealed the notes went from 7/15/18 to 8/13/18 about lab work. The next entry written by licensed nurse/operator F dated 8/17/18 at 8:00 PM included information testing for blood clotting factors and need to hold medication for the weekend. The note indicated staff noted a rash type breakout on the resident back yesterday. Today it was less than the day before and if it persists over the weekend licensed nurse/operator F would report to the physician. There were no follow-up notes on 8/18/18 or 8/19/18 about the appearance of the rash. The next note dated 8/20/18 at 6:00 PM by licensed nurse/operator F included the resident was started on a medication today for shingles. His/her coumadin was restarted today at 4 milligrams daily. The notes lacked an assessment of the area on 8/20/18 and information about contacting the physician about the skin condition. The 8/20/18 at 6:00 PM was the last entry in the record and lacked evidence of monitoring the acute illness, symptoms, actions taken and results of those actions. Observation on 8/29/18 at 10:22 AM with licensed nurse/operator F revealed the resident continued to have 5 small scabbed places on his/her back to the left of the midline. On 8/29/18 at 11:52 AM licensed nurse/operator F confirmed the resident's nursing notes lacked documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions for this resident. The operator failed to ensure the documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of	S5251		

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occurrence, action taken and results of the actions for this resident.

- Record review revealed resident #412 admitted on 8/25/16 with diagnoses of dementia, anxiety, depression, congestive heart failure, history of cerebral vascular accident (stroke), progressive weakness, falls, right foot drop and degenerative disc disease in lumbosacral region.

Record review revealed a functional capacity screen (FCS) dated 8/3/17 and no other FCS. The 8/3/17 FCS indicated the resident needed physical assistance with bathing, dressing, toileting, transfers, mobility and supervision with eating. He/she had short-term and long-term memory deficit, memory/recall deficit and impaired decision making. He/she was at risk for falls and unsteadiness and had impaired vision.

The negotiated service agreement (NSA) dated 8/25/16 recorded the facility provided 3 meals a day with snacks and assistance with eating and the resident needed full assist 2 times a week for bathing. The NSA lacked a description of services for morning and evening cares, toileting, ambulation assistance with devices, needs associated with cognitive deficit, supervised nursing services, management of medication, behavioral symptom management and personal care. The NSA indicated the resident received skilled nursing services from a preferred home health but did not specify who was responsible for payment or what those services included.

Review of the nursing notes between 8/25/16 and 8/20/18 revealed the following:
The nursing notes are dated 12/24/16 with the next note dated 5/3/17. A physician's visit note dated 4/3/17 indicated the resident had coughing

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S5251	Continued From page 32 at time wheezing with oxygen saturation at 91% on room air. The physician ordered a breathing treatment of DuoNeb (bronchodilators which relax the muscles in the airways) 4 times a day for 10 days, an antibiotic for 5 days and an expectorant (loosens and thins mucous) every 12 hours for 7 days. The notes lacked any information about the resident's acute illness, symptoms, actions taken or results of those actions. A nursing note dated 7/27/17 at 10:45 AM about the resident vomiting, then having a fall with head involvement and left by emergency medical services to the emergency room. On 7/27/17 at 3:45 PM licensed nurse K recorded the resident returned was alert to name, requested to lay down, refused lunch but drank apple juice, had oxygen on at 2 liters per nasal cannula, denied pain and orders to start an antibiotic Augmentin 750 milligram twice a day for 10 days. A dictated note from the resident's physician dated 8/1/17 indicated the resident had a chest X-ray on 7/27/17 and the physician ordered to continue the course of Augmentin orders and ensure the resident took the medication with food and call with persistent symptoms. The next entry was dated 11/4/17. The record lacked information about monitoring the acute illness and results of the action taken. A fax sent to the physician dated 12/6/17 indicated the resident reported being sick yesterday and today with coughing that leads to vomiting. Lungs clear currently, he/she reports felling ok and no coughing noted today with a request for a PRN (as needed) medication for cough. Review of the nursing notes revealed a note dated 11/4/17 about a fall and the next note dated 8/20/18. The notes lacked any information about the residents acute illness, symptoms, actions taken or results of those actions.	S5251		

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S5251	Continued From page 33 On 8/29/18 at 11:52 AM licensed nurse/operator F confirmed the resident's nursing notes lacked documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions for this resident. The operator failed to ensure the documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions for this resident.	S5251		
S5312 SS=E	26-42-205 (g) (2) Medication Labeling (g) (2) Each prescription medication container shall have a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (g)(2) The facility reported a census of 4 residents. Based on observation and interview the operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist for resident #407 and #412. Findings included: - On 8/28/18 at 1:40 PM licensed nurse/operator F opened the locked cabinets for resident medication storage. Within the cabinet was a	S5312		

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S5312	Continued From page 34 bottle of Latanoprost (a prescription medication) eye drops with no pharmacist label and no original box which licensed nurse/operator F identified for resident #407. The cabinet also contained a bottle of Timolol (a prescription medication) eye drop without a pharmacist label or original box and licensed nurse/operator F identified for resident #412. Interview on 8/28/18 at 1:45 PM with licensed nurse/operator F revealed the prescription eye drops for both resident's come in a box which had the pharmacist label on it. He/she had directed the certified medication aides and other nurses not to throw the boxes away. He/she did not know why the eye drops did not have boxes with them. The operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist for this resident.	S5312		
S5313 SS=E	26-42-205 (g) (3) Over the counter medication (g) (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.	S5313		

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S5313	Continued From page 35 This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (g)(3) The facility reported a census of 4 residents. Based on observation, interview and record review the operator failed to ensure all over the counter medications were labeled with the full name of the resident for 4 residents who the facility managed his/her medications (#407, #408 #412 and #413). Findings included: - On 8/28/18 the facility provided a resident roster which identified facility management of 4 residents' medications. On 8/28/18 at 1:40 PM licensed nurse/operator F opened the locked cabinets for resident medication storage. Observation revealed the following over the counter (OTC) medications which were not labeled with the resident's full name: Resident #407 had 1 bottle of OTC medication not labeled at all. Resident #408 had 9 bottles/containers of OTC medication labeled with his/her initials. Resident #412 had 5 bottles/containers of OTC medication labeled with first name or last name or initials of the resident. Resident #413 had 2 bottles/containers of OTC medications labeled with first initial and last name, or just initials. The cabinet also contained Acetaminophen 500 milligrams (mg) and a box of allergy tabs labeled with licensed nurse/operator F's first name. A bottle of milk of magnesia and a bottle of antacid	S5313		

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S5313	Continued From page 36 labeled as "Stock". a tube of pain and itch relief cream with no label on the tube or the box. Interview on 8/28/18 at 1:50 PM with licensed nurse/operator F revealed he/she labeled the residents' OTC medications which the resident or family brought in. The operator failed to ensure all over the counter medications were labeled with the full name of the resident.	S5313		
S5325 SS=E	26-42-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist or licensed nurse shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the home and each time the resident experiences any significant change in condition. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(1) The facility reported a census of 4 residents. The sample included 3 residents. Based on record review and interview the licensed nurse/operator failed to conduct a medication regimen review at least quarterly for each resident whose medication was managed by the home (#407, #408 and #412). Findings included:	S5325		

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S5325	Continued From page 37 - Record review for resident #407 revealed an admission date of 6/7/16 with diagnoses of Parkinson's, hypertension and weakness. The annual functional capacity screen (FCS) dated 11/8/17 indicated the resident was unable to safely manage his/her own medications and treatment. The negotiated service agreement (NSA)/health service plan (HSP) dated 6/7/16 recorded the facility provided supervised nursing services, management of medication, behavioral symptom management and personal care. Review of the August 2018 medication administration record revealed the facility administered the resident's medications. Record review revealed licensed nurse/operator F failed to conduct a quarterly review of the resident's medication regimen as follows since the last survey: No review in 8/16, 9/16, 10/16, 11/16 or 12/16 No review in 1/17, 2/17, 3/17, 4/17, 5/17 and 6/17. Licensed nurse/operator F reviewed the resident's medication regimen on 7/11/17 and 9/29/17 with no further reviews for 2017. Licensed nurse/operator F reviewed the resident's medication regimen on 1/18/18 and not again until 6/18/18. Interview on 8/29/18 at 11:08 AM with licensed nurse/operator F confirmed he/she failed to conduct the medication regimen reviews quarterly as required. The licensed nurse/operator failed to conduct a medication regimen review at least quarterly for	S5325		

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this resident whose medication was managed by the home.

- Record review for resident #408 revealed an admission date of 12/1/17 with diagnoses of Parkinson's, hypertension, age related osteoporosis with history of healed osteoporosis fracture.

The admission functional capacity screen (FCS) dated 12/1/17 indicated the resident was not able to manage his/her own medications and treatments.

The negotiated service agreement (NSA)/health service plan (HSP) dated 12/1/17 recorded the facility provided supervised nursing services, medication management, behavioral symptom management and personal care.

Review of the August 2018 medication administration record revealed the facility administered the resident's medications.

Record review revealed licensed nurse/operator F failed to conduct a quarterly review of the resident's medication regimen as follows since the last survey:
Licensed nurse/operator F reviewed the resident's medication regimen upon admission 12/1/17 and not again until 6/18/18.

Interview on 8/29/18 at 10:35 AM with licensed nurse/operator F revealed he/she confirmed the record lacked evidence of a medication regimen review between 12/1/17 and 6/18/18 (6 months). He/she said he/she must have missed the review in March.

The licensed nurse/operator failed to conduct a

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S5325	Continued From page 39 medication regimen review at least quarterly for this resident whose medication was managed by the home. - Record review revealed resident #412 admitted on 8/25/16 with diagnoses of dementia, anxiety, depression, congestive heart failure, history of cerebral vascular accident (stroke), progressive weakness, falls, right foot drop and degenerative disc disease in lumbosacral region. Record review revealed a functional capacity screen (FCS) dated 8/3/17 which identified the resident had short-term and long-term memory deficit, memory/recall deficit and impaired decision making. He/she was unable to manage his/her own medications and treatments. The negotiated service agreement (NSA)/health service plan (HSP) dated 8/25/16 recorded the facility provided supervised nursing services, management of medication, behavioral symptom management and personal care. Review of the August 2018 medication administration record revealed the facility administered the resident's medications. Record review revealed licensed nurse/operator F failed to conduct a quarterly review of the resident's medication regimen as follows since the last survey: No reviews were conducted in 8/16, 9/16, 10/16, 11/16 or 12/16 No reviews were conducted in 1/17, 2/17, 3/17, 4/17 and 5/17. Licensed nurse/operator F conducted a medication review on 6/1/17 and not again until 11/2/17. Licensed nurse/operator F conducted a review on 1/24/18 and not again until 6/18/18.	S5325		

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S5325	Continued From page 40 Interview on 8/29/18 at 11:08 AM with licensed nurse/operator F confirmed he/she failed to conduct a quarterly review of the resident's medication regimen. The licensed nurse/operator failed to conduct a medication regimen review at least quarterly for this resident whose medication was managed by the home.	S5325		