STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N064002	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNCIL GROVE ASSISTED LIVING	554 COUNTRY LANE COUNCIL GROVE, KS 66846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey of the above assisted living facility on 5/16/18, 5/21/18, 5/22/18, and 5/23/18.	S 000		
S 190 SS=D	26-39-102 (e) Admission, Transfer, Discharge (e) Before a resident is transferred or discharged involuntarily, the administrator or operator, or the designee, shall perform the following: (1) Notify the resident, the resident ' s legal representative, and if known, a designated family member of the transfer or discharge and the reasons; and (2) record the reason for the transfer or discharge under any of the circumstances specified in paragraphs (d) (1) through (4) in the resident ' s clinical record, which shall be substantiated as follows: (A) The resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met by the adult care home; (B) the resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the adult care home; and (C) a physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary because the health or safety of other individuals in the adult care home is endangered.	S 190		

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

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S 190	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-39-102(e)(2)(A) The facility reported a census of 22 residents. The sample included 3 residents. Based on record review and interview for 1 (#252) of 3 residents sampled, the operator failed to ensure the resident's record contained documentation of the reason for the involuntary discharge including the medical care provider's documentation of the rationale for discharge in the resident's clinical record when the discharge was necessary for the resident's welfare and the resident's needs could not be met by the facility. Findings included: - Record review for resident #252 revealed an admission date of 1/28/17 with diagnoses of coronary artery disease, hypertension, osteoarthritis, rheumatoid arthritis, non-insulin dependent diabetes mellitus, and peripheral vascular disease. Functional capacity screen dated 1/18/18 indicated resident was independent with transferring and toileting; required supervision with dressing and eating; required physical assistance with bathing and toileting; was unable to self-manage medications and treatments; was occasionally incontinent of urine; experienced impaired short term memory and memory recall; speech rarely or never understandable and sometimes understood communication by others; was at risk for falls; experienced impaired vision and hearing; and displayed socially inappropriate disruptive behavior.	S 190		

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S 190	Continued From page 2 Negotiated service agreement/health care service plan (NSA/HCSP) dated 1/20/18 documented services of physical assistance with bathing; dressing assistance as needed; administration of medications and treatments; and extra housekeeping services due to bowel incontinence; and laundry 2 times a week after bathing and as needed. The NSA/HCSP documented resident required physical assistance with toileting and/or frequent reminders during the day to manage incontinence; resident must participate in incontinence management and the use of the toilet; and may require change of clothing 2 to 3 times a week. Incontinent bowel episodes occur occasionally. Staff to assist with clothing change and shower. Nurses notes contained an entry by licensed nurse C at 2:00 p.m. on 4/12/18 that resident had increase in bowel incontinence, family provided incontinence product, and staff working with resident. On 5/2/18 at 6:00 p.m. licensed nurse C documented resident continues with bowel incontinence and unable to clean self, training continues. Licensed nurse C documented at 1:00 p.m. on 5/15/18 that a 30-day notice was given to resident's durable power of attorney by operator and this nurse with letter sent this day. The nurse's notes lacked documentation of the reason for the involuntary discharge notice. The record lacked documentation from the resident's medical care provider of the rationale for discharge, that discharge was necessary for the resident's welfare, and the resident's needs could not be met by the facility. The resident's admission agreement dated 1/28/17 documented in the section regarding	S 190		

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S 190	Continued From page 3 termination of the agreement "A physician's letter must be given to the director, stating the need for the resident to be moved." During an interview at 3:40 p.m. on 5/16/18, licensed nurse C explained resident had become incontinent of bowel and could not self-manage which was a requirement to continue living in the facility. Licensed nurse C stated staff had tried to educate resident to use incontinence product and independent personal hygiene without success as the reason for involuntary 30-day discharge notice. Licensed nurse C confirmed the record lacked documentation from the resident's physician that a discharge was indicated due to facility unable to meet resident's needs. The operator failed to ensure resident #252's record contained documentation of the reason for the involuntary discharge including the medical care provider's documentation of the rationale for discharge in the resident's clinical record when the discharge was necessary for the resident's welfare and the resident's needs could not be met by the facility.	S 190		
S 200 SS=D	26-39-102 (g) Written Discharge Notice Requirements (g) Each written transfer or discharge notice shall include the following: (1) The reason for the transfer or discharge; (2) the effective date of the transfer or discharge; (3) the address and telephone number of the complaint program of the Kansas department on aging where a complaint related to involuntary transfer or discharge can be registered; (4) the address and telephone number of the state long-term care ombudsman; and	S 200		

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S 200	Continued From page 4 (5) for residents who have developmental disabilities or who are mentally ill, the address and telephone number of the Kansas advocacy and protection organization. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(g)(2)(3)(4) The facility reported a census of 22 residents. The sample included 3 residents. Based on record review and interview for 1 (#252) of 3 residents sampled, the operator failed to ensure the written discharge notice provided to the resident's durable power of attorney care included the effective date of the discharge, the address and telephone number of the complaint program of the Kansas department for aging and disability services where a complaint related to the involuntary discharge could be registered, and the address and telephone number of the state long-term care ombudsman. Findings included: - Record review for resident #252 revealed an admission date of 1/28/17 with diagnoses of coronary artery disease, hypertension, osteoarthritis, rheumatoid arthritis, non-insulin dependent diabetes mellitus, and peripheral vascular disease. Functional capacity screen dated 1/18/18 indicated resident was independent with transferring and toileting; required supervision with dressing and eating; required physical assistance with bathing and toileting; was unable	S 200		

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S 200	Continued From page 5	S 200		

to self-manage medications and treatments; was occasionally incontinent of urine; experienced impaired short term memory and memory recall; speech rarely or never understandable and sometimes understood communication by others; was at risk for falls; experienced impaired vision and hearing; and displayed socially inappropriate disruptive behavior.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 1/20/18 documented services of physical assistance with bathing; dressing assistance as needed; administration of medications and treatments; and extra housekeeping services due to bowel incontinence; and laundry 2 times a week after bathing and as needed. The NSA/HCSP documented resident required physical assistance with toileting and/or frequent reminders during the day to manage incontinence; resident must participate in incontinence management and the use of the toilet; and may require change of clothing 2 to 3 times a week. Incontinent bowel episodes occur occasionally. Staff to assist with clothing change and shower.

Nurses notes contained an entry by licensed nurse C at 2:00 p.m. on 4/12/18 that resident had increase in bowel incontinence, family provided incontinence product, and staff working with resident. On 5/2/18 at 6:00 p.m. licensed nurse C documented resident continues with bowel incontinence and unable to clean self, training continues. Licensed nurse C documented at 1:00 p.m. on 5/15/18 that a 30-day notice was given to resident's durable power of attorney by operator and this nurse with letter sent this day.

At 3:50 p.m. on 5/16/18, operator provided a copy

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S 200	Continued From page 6 of the discharge notice mailed to resident's durable power of attorney dated 5/15/18 documenting resident's inability to self-manage bowel incontinence as the reason for discharge. The letter lacked the effective date of the discharge, the address and telephone number of the complaint program of the Kansas department for aging and disability services where a complaint related to the involuntary discharge could be registered, and the address and telephone number of the state long-term care ombudsman. The operator failed to ensure the written discharge notice provided to the resident #252's durable power of attorney care included the effective date of the discharge, the address and telephone number of the complaint program of the Kansas department for aging and disability services where a complaint related to the involuntary discharge could be registered, and the address and telephone number of the state long-term care ombudsman.	S 200		
S 230 SS=D	26-39-102 (b) (c) Admission Advanced Directives Resident Rights b) At the time of admission, adult care home staff shall inform the resident or the resident ' s legal representative, in writing, of the state statutes related to advance medical directives. (1) If a resident has an advance medical directive currently in effect, the facility shall keep a copy on file in the resident ' s clinical record. (2) The administrator or operator, or the designee, shall ensure the development and implementation of policies and procedures related to advance medical directives. (c) The administrator or operator, or the	S 230		

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S 230	Continued From page 7 designee, shall provide a copy of resident rights, the adult care home's policies and procedures for advance medical directives, and the adult care home's grievance policy to each resident or the resident's legal representative before the prospective resident signs any admission agreement. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(b)(1) The facility reported a census of 22 residents. The sample included 3 residents. Based on record review and interview for 1 (#251) of 3 residents sampled, the operator failed to ensure the resident's record contained a copy of the resident's advance medical directive currently in effect. Findings included: - Record review for resident #251 revealed an admission date of 4/7/17 with diagnoses of coronary artery disease, hypertension, pulmonary embolism, and deep vein thrombosis. Functional capacity screen dated 1/10/18 indicated resident required physical assistance with toileting, transferring, mobility with walker, and eating; was unable to bathe self, dress self, and management medications and treatments; experienced impaired short-term memory, long-term memory, memory recall, and decision making. The negotiated service agreement/health care service plan dated 1/10/18 documented facility staff to provide assistance with activities of daily living and administer	S 230		

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S 230	Continued From page 8 medications and treatments. The resident's record contained a "Do Not Resuscitate" form that contained the signature of the resident's responsible party and a witness. The form lacked the signature of the resident's medical care provider. Review of the resident's admission agreement revealed resident was given information regarding advance medical directives but the responsible party did not indicate if the resident had an advance directive. At 10:35 a.m. on 5/22/18, licensed nurse C confirmed the medical care provider had not signed the do not resuscitate form to ensure resident's directive would be upheld. The operator failed to ensure the record of resident #251 contained a copy of the resident's advance medical directive currently in effect.	S 230		
S3145 SS=F	26-41-203 (e) Routine Maintenance (e) Maintenance. Designated staff shall provide routine maintenance, including the control of pests and rodents, and repairs in each resident's bedroom and common areas inside and outside the facility as specified in the admission agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-203(e) The facility reported a census of 22 residents.	S3145		

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S3145	Continued From page 9 The sample included 3 residents. Based on observation and interview for all residents, the operator failed to ensure designated staff provided routine maintenance including the control of rodents in the facility. Findings included: - During tour of the kitchen at 1:56 p.m. on 5/16/18, surveyor opened the door to a closet with a floor sink and storage of mop and cleaning supplies. Surveyor observed a mop head draped over a bucket with a mouse running over the mop head to the back of the closet. Surveyor closed door and noted a gap between the bottom of the door and the floor. The pantry with storage of dry food items was directly across from the cleaning closet. Surveyor observed foods with plastic packaging such as dry egg noodles and bag of marshmallows in pantry and under the shelving there was a mouse trap device. Dietary employee F stated he/she had not seen mice or evidence of mice. Dietary employee F reported presence of mouse to operator. During an interview at 2:05 p.m. on 5/16/18, operator stated he/she would call exterminator service regarding control of mice. At 3:37 p.m. on 5/22/18, operator B stated exterminator came today and sprayed but as far as he/she knew exterminator did not address control of mice. Operator B could not provide documentation from an exterminator of any prior rodent control. Operator stated he/she would be contacting another company for exterminator services. For all residents, the operator failed to ensure	S3145		

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S3145	Continued From page 10 designated staff provided routine maintenance including the control of rodents in the facility.	S3145		
S3155 SS=D	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 22 residents. The sample included 3 residents. Based on record review, interview, and observation for 1 (#251) of 3 residents sampled, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #251 revealed an admission date of 4/7/17 with diagnoses of coronary artery disease, hypertension, pulmonary embolism, deep vein thrombosis, and history of	S3155		

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S3155	Continued From page 11 stroke with left hemiparesis. Functional capacity screen dated 1/10/18 indicated resident required physical assistance with transferring and mobility; was at risk for falling; and experienced impaired short-term memory, long term memory, memory recall, and decision making. Resident's negotiated service agreement/health care service plan (NSA/HCSP) dated 1/10/18 documented staff to cue and or assist with transferring and provide stand-by assistance with ambulation with walker. Nurse's notes contained an entry by licensed nurse C at 8:30 p.m. on 5/7/17 that resident was unable to sit up on edge of bed and resident stated, "I just need something to hang on to." Licensed nurse C documented he/she sent fax to medical care provider requesting an order for a "1/4 turn rail." At 2:30 p.m. on 5/8/17, licensed nurse E documented order received for 1/4 turn rail to be placed on resident's bed to help with independence of bed mobility. Placed on bed at this time. Resident's record lacked an assessment of the safety of the mobility device and resident's ability to safely use the device for bed mobility. Resident's NSA/HCSP lacked a description of the resident's use of a bed mobility device. At 10:05 a.m. on 5/16/18, observed sampled resident #251 walking in hallway with walker. A certified staff member held on to the resident's waistband of clothing and pulled a wheelchair behind resident. Resident's walked with an unsteady gait.	S3155		

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S3155	Continued From page 12 During an interview at 10:35 a.m. on 5/22/18, licensed nurse C stated he/she had observed resident safely use bed mobility device to get in and out of bed. Licensed nurse C stated he/she did not assess the safety of the device and did not know if resident could become entrapped. Licensed nurse C stated the device was not attached to the bed but slid between the mattress and box springs. Licensed nurse C confirmed the resident's NSA/HCSP did not described resident's need for a bed mobility device. Licensed nurse C stated staff were to assist resident with ambulation using a gait belt to support resident while resident walked with a walker. Licensed nurse C confirmed the NSA/HCSP lacked a description of this service. During an interview with resident in his/her apartment, surveyor observed a quarter rail on the side of the bed. Surveyor noted the bars slid freely between mattress and box springs causing the rail to move out away from side of bed. Resident stated he/she held on to the rail to get in and out of bed. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #251 and were in accordance with the functional capacity screening and the negotiated service agreement.	S3155		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all	S3200		

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S3200	Continued From page 13 medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 22 residents. The sample included 3 residents. Based on record review and interview for 1 (#250) of 3 residents sampled, the operator failed to ensure licensed nurses and medication aides administered medications to the resident in accordance with a medical care provider's written order. Findings included: - Record review for resident #250 revealed an admission date of 11/1/17 with diagnoses of coronary artery disease, hypertension, osteoarthritis, depression, and trigeminal neuralgia. Functional capacity screen dated 11/1/17 indicated resident was unable to perform medication and treatment management.	S3200		

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S3200	Continued From page 14 Negotiated service agreement/health care service plan dated 11/1/17 documented facility staff administered medications and treatments to the resident. Comparison of the May 2018 medication administration record (MAR) with the written medical care provider's orders revealed the following: Nitroglycerin tablets 0.4 milligrams (mg) 1 tablet under tongue every 5 minutes as needed for relief of chest pain written by medical care provider 2/13/18 and not listed on the MAR. Diclofenac (anti-inflammatory for arthritis pain) 1% gel 2 grams topical 4 times a day to the affected area written by medical care provider 12/15/17. The Diclofenac was not listed on the MAR. The record contained documentation of an office visit to the medical care provider on 4/19/18 that listed resident's medications. Comparison of the medication list with the May 2018 MAR revealed the following discrepancies: Medical care provider listed Neurontin (for trigeminal neuralgia pain) 100 mg capsules take 3 capsules by mouth at bedtime. The MAR documented resident received Neurontin 100 mg 2 tablets by mouth at 7:00 a.m. and 5:30 p.m. and 100 mg 1 tablet by mouth at 12:00 p.m. Medical care provider listed Prozac (for depression) 20 mg by mouth daily. May 2018 MAR documented Prozac 10 mg by mouth daily. Medical care provider listed Percocet (oxycodone/acetaminophen 5/325 mg for pain relief) 1 to 2 tablets every 4 to 6 hours by mouth as needed for pain. The May 2018 MAR listed Percocet 5/325 mg 1 tablet every 4 hours as	S3200		

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S3200	Continued From page 15 needed for pain. During an interview at 10:21 a.m. on 5/22/18, licensed nurse C stated he/she did not know why the ordered nitroglycerin and Diclofenac gel were not listed on the May 2018 MAR. Licensed nurse C stated he/she needed to clarify with medical care provider the dosages and administration times for Prozac, Neurontin, and Percocet. The operator failed to ensure licensed nurses and medication aides administered medications to resident #250 in accordance with a medical care provider's written order.	S3200		
S3211 SS=F	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: KAR 26-41-205(g)(3) The facility reported a census of 22 residents.	S3211		

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S3211	Continued From page 16 The sample included 3 residents. Based on record review, interview, and observation for all residents receiving facility management of medications, the operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on each over-the-counter (OTC) medication package or container. Findings included: - Resident roster documented the facility provided medication management for 21 of the 22 residents living in the facility. At 3:08 p.m. on 5/16/18 certified medication aide (CMA) D unlocked the medication cart located in the medication room. CMA D opened the second and third drawers of the cart and surveyor observed numerous OTC medications for residents without the full name of the resident. CMA D stated the day-shift CMA labeled each OTC medication container or packaging. Resident #253: Bottle of Stool softener tablets and a bottle of antacid tablets labeled with resident's room number, first initial, and last name. Omeprazole (stomach acid reducer) labeled with room number and last name. Naproxen sodium (anti-inflammatory) with room number. Resident #254: Aspirin labeled with first initial, last name, and room number. Omeprazole labeled with room number and initials. Occu-soft lid scrub without a resident name. CMA D stated these belonged to resident #254.	S3211		

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S3211	Continued From page 17 Resident # 255: Laxative powder, acetaminophen (pain reliever/fever reducer), Ester-C (supplement), Gentle iron (supplement), Benadryl (antihistamine) each labeled with resident's room number, first initial, and last name. Resident #256: Multivitamin labeled with room number, first initial, and last name. Resident #257: Aspirin labeled with room number and last name. Melatonin (supplement) labeled with room number. Cranberry concentrate (supplement) labeled with room number and resident's initials. Unisom (sleep aid) labeled with room number, first initial, and last name. Resident #258: Aspirin labeled with resident's first initial and last name. Resident #259: Aspirin labeled with room number, first initial, and last name. Resident #260: Aspirin labeled with room number, first initial, and last name. Resident #261: Colace (stool softener) labeled with room number, first name, and last initial. Multivitamin, Ester-C, and Citracal (supplement) each container labeled with resident's initials. The third drawer contained more OTC medication	S3211		

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S3211	Continued From page 18 packages not listed. At 3:18 p.m. on 5/16/18, licensed nurse C entered the medication room and stated facility policy for labeling OTC medications as the person on duty, a CMA or licensed nurse, when the medication is delivered to the facility was to place the resident's room number, name, and date opened on the medication package or container. During an interview at 4:10 p.m. on 5/16/18, when asked for the facility's policy for labeling OTC medications, operator B and licensed nurse C provided a copy of the regulation at KAR 26-41-205(g)(3). For all residents receiving facility management of medications, the operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on each over-the-counter medication package or container.	S3211		
S3265 SS=F	26-41-104 (a) Disaster and Emergency Preparedness (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(a)	S3265		

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S3265	Continued From page 19 The facility reported a census of 22 residents. The sample included 3 residents. Based on record review, interview, and observation for all residents, the operator failed to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. Findings included: - During an interview at 10:09 a.m. on 5/16/18, operator B stated 2 direct care staff on duty in the facility from 6:00 a.m. until 10:00 p.m. and from 10:00 p.m. to 6:00 a.m. only 1 direct care staff on duty. Operator B provided documentation of an evacuation of residents to a secure location on 3/6/17 and 3/13/18. The documentation dated 3/6/17 included 3 employees participating in the evacuation of residents in 7 minutes. Three employees participated in the evacuation of residents to a secure location in 10 minutes on 3/13/18. Interview at 11:58 a.m. on 5/16/18, operator B stated he/she had not conducted an emergency drill with one employee evacuating residents to a secure location. At 10:05 a.m. on 5/16/18, observed sampled resident #251 walking in hallway with walker. A certified staff member held on to the resident's waistband of clothing and pulled a wheelchair behind resident. Resident's functional capacity screen dated 1/10/18 indicated resident required physical assistance with transferring and mobility and experienced impaired cognition. Resident's negotiated service agreement/health care service plan dated 1/10/18 documented staff to cue and or assist with transferring and provide stand-by assistance with ambulation with walker.	S3265		

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S3265	Continued From page 20 Review of the functional capacity screen dated 1/18/18 for resident #252 revealed resident was independent with transferring and mobility, experienced impaired cognition, and difficulty communicating and understanding communication. Negotiated service agreement/health care service plan dated 1/20/18 documented resident required cueing, redirection, and reorientation. For all residents, the operator failed to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location.	S3265		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location.	S3280		

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S3280	Continued From page 21 This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 22 residents. The sample included 3 residents. Based on record review and interview for all residents and all employees, the operator failed to ensure disaster and emergency preparedness by ensuring the performance of a quarterly review of the facility's emergency management plan with employees and residents. Findings included: - At 11:28 a.m. on 5/16/18, operator B provided documentation of staff in-services. No documentation provided of the review of the emergency management plan from April to December 2016. The in-service 3/29/17 contained documentation of a review of the entire plan. The in-service 6/21/17 documented "Disaster Plan." The 9/23/17 in-service documented review of only fire prevention and safety. In-service 12/20/17 documented "Emergency Plan." In-service 4/25/18 only included fire and tornado plan. Interview at 11:39 a.m. on 5/16/18, operator B stated he/she reviewed a part of the emergency management plan with employees each quarter and not the entire plan each quarter. Review of resident council minutes revealed the emergency management plan was reviewed with residents only on 3/13/17 and 6/29/17. During an interview at 11:58 a.m. on 5/16/18, operator B stated he/she had not reviewed the plan with residents in 2018 and could not provide	S3280		

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S3280	Continued From page 22 documentation of any additional reviews in 2016 and 2017. For all residents and all employees, the operator failed to ensure disaster and emergency preparedness by ensuring the performance of a quarterly review of the facility's emergency management plan with employees and residents.	S3280		