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	N078015	A. BUILDING: _____ B. WING _____	05/04/2018

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S 000	INITIAL COMMENTS The following citations represent the findings of a licensure resurvey for the above named facility with complaint investigation #119364 on 4/30/18, 5/1/18, 5/2/18 and 5/4/18.	S 000		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 111 residents. The sample included 6 residents with 3 of those having falls in past 180 days. Based on observation, record review and interview the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of each resident and were in accordance with the functional capacity screening and negotiated service agreement for 1 of 3 sampled residents (#401) regarding falls. Findings included: - Record review for resident #401 revealed an	S3155		

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

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S3155	Continued From page 1	S3155		

admission date of 7/30/14 and diagnoses of: dementia with behaviors, Alzheimer's disease, type 2 diabetes mellitus, hypertension and depression.

The annual Functional Capacity Screen (FCS) dated 10/11/17 indicated the resident had a cognition score of 4 with deficit in short and long-term memory, memory/recall and decision making. He/she needed physical assistance from staff for dressing and toileting with independence for transfers and ambulation with the use of an assistive device (walker). The FCS indicated the resident had falls and unsteadiness.

The Negotiated Service Agreement (NSA)/Personal Service Plan (PSP) dated 10/11/17 included staff provide attention and/or verbal prompts to and from the dining room and/or community activities as needed. Memory impairment is one of the reasons for the escort assistance. Be alert for heightened risk for falling, resident has fallen in last 12 months with an injury that needed emergency room treatment/assessment. He/she uses a walker as a mobility aide. The resident is frequently incontinent of bladder, continent of bowel and will ask staff for directions to restroom. Resident could self-toilet, including perineal care and managing clothing. Staff to provide one assist with changing of incontinent products as needed. Staff to check resident for incontinence periodically throughout the day. The NSA/PSP included the following updates:
12/12/17 fall in bathroom interventions included: staff make frequent rounds every 1 hour, ensure proper footwear, planned eye surgery in am, encourage fluids per physician order, frequent reminders to use walker and non-skin strips.
12/14/17 fall in another resident's room with

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S3155	Continued From page 2	S3155		

intervention of outside provider to be with resident due to eye surgery and difficulty for resident to see.
12/15/17 fall in bathroom of another resident's room. Interventions included: non-skin strips applied (did not say if that was too other resident's bathroom since this resident already had that as intervention), stand by assist (SBA) with ambulation, eye medication as ordered, outside provider 1 on 1 with resident from 1:00 PM to 10:00 PM between 12/15-17/17 and paint wall behind toilet for contrast.

Review of the resident log (nursing notes) revealed the following:
12/12/17 at 9:30 AM indicated the resident fell on 12/11/17 at 9:30 PM when staff observed the resident sitting on his/her bottom in between the toilet and sink. The resident did not know how she ended up in that position. The nurse assessed with no noted injury. Interventions included increase rounds to every 1 hour, ensure proper footwear and offer frequent reminders to use his/her walker.
12/13/17 at 1:19 PM resident returned from eye surgery with a family member around noon.
12/14/17 at 6:00 PM the resident had a non-injury fall on 12/13/17 at 9:31 PM in doorway of another resident's room. Outside source to sit with resident throughout the weekend post eye surgery.
12/15/17 at 1045 AM staff found the resident in another resident's bathroom sitting on the floor with pants partway down and large bowel movement on the floor. Resident reported not knowing what happened. Resident stated he/she must have missed the toilet. Intervention for SBA with ambulation, apply non-skid strips in other resident's bathroom for safety. Resident was toileted prior to breakfast and last seen in the

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S3155	Continued From page 3	S3155		

dining area around 8:55 AM and resident had left walker in the dining room.
1/2/18 at 3:52 PM indicated the resident had a non-injury fall on 1/1/18 at 7:50 PM when staff found the resident laying on the floor in the hallway with his/her pants down and urine on the floor. (neither the note or the NSA/PSP include any intervention to prevent future falls. Per interview on 5/1/18 at 3:45 PM licensed nurse B confirmed no evaluation of the resident's toileting needs was completed in relation to the repeated falls around toileting)
1/19/18 at 5:35 PM resident found in hallway sitting on buttocks with back against the wall. The resident said he/she had fallen. Resident did not have his/her walker so staff retrieved the walker from the resident's room. Intervention included Occupational Therapy related to poor vision.
1/30/18 at 7:46 PM indicated the resident had a non-injury fall at 2:30 PM that day while in the hallway heading towards his/her room. The resident fell backwards and staff could not get there in time. The resident told the staff he/she was putting on shoes. (the note and the NSA/PSP lacked any information related to why the resident was not wearing proper footwear from a previous intervention, why the resident was ambulating without SBA as previously planned and lacked an additional intervention to prevent future falls of this nature.

Observation on 4/30/18 at 10:24 AM revealed the resident laying on the floor in the hallway about 15-20 feet from his/her room. Licensed nurse B confirmed the resident had fallen and was walking without staff assistance. Direct care staff F retrieved the resident's walker from his/her room.

Interview on 4/30/18 at 1:20 PM with direct care

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S3155	Continued From page 4 staff F revealed the resident the resident only needed staff assistance with dressing. The resident was a fall risk and had frequent falls due to poor vision, forgetting his/her walker and poor balance. He/she said staff does not walk with the resident or assist him/her to the bathroom only remind him/her to use the walker if staff saw him/her without it. Interview on 5/1/18 at 3:45 PM with licensed nurse B confirmed no additional interventions were put in place after the 1/1/18 and 1/30/18 falls. He/she reported staff were just visualizing more often and waiting for the resident to have cataract surgery to improve his/her vision. Nurse B confirmed the facility did not have any evidence of the planned hourly visualizations. He/her confirmed the resident had multiple falls related to toileting needs but did not have any assessment of needs or changes in the NSA/PSP to address the change in toileting needs especially related to poor vision. Interview on 5/1/18 at 4:25 PM with administrator E confirmed the red toilet seat was not added until after ordering on 2/4/18. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident and in accordance with the functional capacity screening and negotiated service agreement for #401 regarding falls.	S3155		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its	S3211		

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S3211	Continued From page 5 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 111 residents. The facility had 3 medication carts, 1 treatment cart and 2 medication rooms. Based on observation and interview the facility 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 located in 3 of 4 medication carts. Findings included: - The resident roster identified 84 residents received facility management of medications. On 4/30/18 at 9:59 AM certified medication aide (CMA) A unlocked medication cart #1 and observation revealed the following over the counter (OTC) medications/vitamins which were opened and labeled only with a room number: I-caps (a vitamin for eyesight), Vitamin C 1000 mg tablets, Fish oil 1200 mg capsule and Multivitamin adult 50+. The medication cart also	S3211		

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S3211	Continued From page 6 had Calcium 600 milligrams (mg) with vitamin D opened, labeled with a room number and a resident's last name and Antifungal Powder 2% opened and labeled with a room number and gender identifier. Licensed nurse D opened the treatment cart which had a bottle of Antacid 500 mg tablets and a bottle of Tums (antacid) 750 mg tablets which were opened and labeled with only a room number. On 4/30/18 at 10:45 AM licensed nurse B unlocked the medication cart on the memory care unit. Observation revealed open OTC bottles and containers labeled with a room number only as follows: Calcium 500 mg tablets, Viactiv Calcium + vitamin D chews 2 different containers each labeled with a room number only. A bottle of Systane Balance eye drops with no name or identifier and opened. Interview on 4/30/18 at 9:59 AM with licensed nurse C confirmed the OTC medication was labeled by a nurse and did not know it required labeling with the resident's first and last name. Interview on 4/30/18 at 10:45 AM with licensed nurse B revealed he/she did not know the OTC medications needed the resident's first and last name. The facility 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		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness	S3280		

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S3280	Continued From page 7 (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. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3)(4) The facility reported a census of 111 residents. The sample included 6 residents. Based on interview and record review the administrator failed to ensure the residents who did not attend the monthly council meetings had disaster and emergency preparedness by a failure to provide a quarterly review of the facility's emergency management plan. The administrator also failed to ensure all resident could be evacuated to a secure location with the least amount of staff on duty at any time. Findings included: - On 4/30/18 a request was made to review the last 2 annual fire evacuations of the residents to a	S3280		

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S3280	Continued From page 8	S3280		

secure location. The facility evacuation for 2016 took place on 8/6/16 at 12:26 PM with 17 staff and took 45 minutes. Interview on 4/30/18 at 111:50 AM with licensed nurse D revealed the facility had 5 staff on duty between the hours of 10:00 PM and 6:00 AM. The 2017 total evacuation on 8/2/17 at 3:00 PM had 21 staff and took 16 minutes.

Interview on 4/30/18 at 11:50 AM with administrator E revealed he/she did not know the evacuation should be done with the least amount of staff to ensure all residents can be evacuated to a secure location in a reasonable amount of time even when the facility had a sprinkler fire suppression system.

The facility provided the resident council minute book for evidence of the residents' quarterly review of the facility emergency management plan.

Review of the monthly resident council meeting minutes revealed a review of the emergency management plan every three-month period as follows: 7/7/16, 10/5/16, 1/6/17, 4/5/17, 7/5/17, 10/4/17, 1/3/18 and 4/4/18. None of these meeting identified which or how many residents attended.

During an interview at 11:50 AM on 4/30/18, administrator C confirmed only the residents who attended those council meetings received emergency disaster management review. He/she confirmed there was no record of which residents attended. He/she said about 50% of the residents attended those meetings.

The administrator failed to ensure disaster and emergency preparedness of residents and

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S3280	Continued From page 9 employees by a failure to provide a quarterly review of the facility's emergency management plan.	S3280		