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	N040008	A. BUILDING: _____ B. WING _____	05/07/2018

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THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with investigation of complaint #128733 of the above assisted living facility on 5/1/18, 5/2/18, 5/3/18, and 5/7/18.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1)(2)(3) 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 development of a written negotiated service agreement that included identification of an outside resource, a description of services	S3085		

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

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S3085	Continued From page 1	S3085		

provided, and the party responsible for payment of the services provided by the outside resource.

Based on record review and interview for 1 (#250) of 3 residents sampled, the operator failed to ensure the resident's negotiated service agreement included the party responsible for payment of services provided by hospice.

Findings included:

- Record review for resident #251 revealed an admission date of 1/26/18 with diagnoses of type 2 diabetes, neuropathy, congestive heart failure, dementia, and hypertension.

The medical care provider's admission order dated 1/25/18 included an order for resident to receive speech therapy, physical therapy, and occupational therapy.

Record contained a medical care provider's visit note dated 4/7/18 that documented physical therapy and occupational therapy continued to work with resident.

Resident's negotiated service agreement dated 1/26/18 lacked the identification of the therapy provider, the services provided, and the party responsible for payment of therapy services.

During an interview at 1:34 p.m. on 5/2/18 licensed nurse C stated the resident's negotiated service agreement did not include therapy services.

Operator B failed to ensure the development of a written negotiated service agreement for resident #251 that included identification of an outside resource, a description of services provided, and

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S3085	Continued From page 2 the party responsible for payment of the services provided by the outside resource. - Record review for resident #250 revealed an admission date of 9/1/17 with diagnoses of arteriosclerotic heart disease, osteoarthritis, and dementia. Negotiated service agreement dated 2/28/18 documented the name of hospice providing services of skilled nursing visit 2 times a week and home health aide to assist with bathing 3 times a week. The negotiated service agreement did not list the party responsible for payment of the services provided by hospice. During an interview at 1:56 p.m. on 5/2/18, licensed nurse C confirmed the resident's negotiated service agreement did not specify the party responsible for payment of hospice services. Operator B failed to ensure the resident's negotiated service agreement included the party responsible for payment of services provided by hospice.	S3085		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S3155		

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S3155	Continued From page 3 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 and interview for 1 (#251) of 3 residents sampled, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident related to resident's falls and risk for falls and glucometer testing in accordance with the resident's functional capacity screen and negotiated service agreement. Based on record review, interview, and observation for 1 (#250) of 3 residents sampled, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident related to falls and risk for falls, toileting assistance, and use of a positioning device in accordance with the resident's functional capacity screen and negotiated service agreement. Based on record review, observation, and interview for 1 (#252) of 3 residents sampled, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident related to resident's wandering behavior, risk for falls, and use of a positioning device.	S3155		

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S3155	Continued From page 4 Findings included: - Record review on 5/1/18 for resident #251 revealed an admission date of 1/26/18 with diagnoses of type 2 diabetes mellitus, neuropathy, congestive heart failure, hypertension, osteoarthritis, and dementia. Functional capacity screen dated 1/26/18 indicated resident was independent with dressing, toileting, and transferring; required supervision with bathing and mobility with a walker or wheelchair; did not experience impaired cognition; and was at risk for falls. Negotiated service agreement/health care service plan dated 1/26/18 documented staff provided stand-by assistance for bathing and resident independent ambulating with walker. Record contained a fall risk assessment dated 3/15/18 that scored risk at '20' with instruction on form that if total score equal to or greater than 10 that a care plan with interventions "must be put into place immediately." Clinical notes contained the following entries: 3/12/18 at 8:25 a.m. licensed nurse C documented he/she received a call from staff at 7:50 a.m. to report resident called for assistance at 7:40 a.m. and had fallen. Resident stated he/she was on way back from bathroom using walker, tripped, hit head on a drawer handle, and had a laceration to left side of head. Resident transported by ambulance to hospital. 3/12/18 at 12:11 p.m. licensed nurse C documented resident returned from hospital with steri-strips to laceration on forehead.	S3155		

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S3155	Continued From page 5 3/13/18 at 9:05 a.m. licensed nurse C documented he/she received a call at 5:21 p.m. (3/12/18) from staff that resident had a scalp laceration to left lateral side of head. Licensed nurse C assessed the laceration that was buried under blood matted hair. Laceration jagged and measured 6-7 centimeters long. Resident sent to hospital by ambulance and returned to facility with 7 staples to laceration. Note: NSA/HCSP lacked revision to include interventions to address resident's risk for falls. 4/5/18 at 11:59 a.m. licensed nurse C documented a staff member entered resident's room and observed resident sitting on floor between recliner and door to room and walker by bathroom door. Resident stated he/she had fallen asleep in recliner, woke up to go to bathroom, and then back to bed. Resident stated he/she missed bed (causing fall) and scooted self to area where staff found him/her. Call pendant was on walker. Medical care provider in to see resident and ordered lab work and a consultation with a vestibular therapist due to resident's complaint of dizziness. Note: NSA/HCSP lacked revision to include interventions to address resident's risk for falls. 4/20/18 at 7:50 a.m. licensed nurse C documented staff called to report resident fell against bathroom door when attempting to go to bathroom. No injuries noted and licensed nurse C instructed staff to assist resident up from floor. Note: NSA/HCSP lacked revision to include interventions to address resident's risk for falls.	S3155		

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S3155	Continued From page 6 The medical care provider's admission order dated 1/25/18 included an order for resident to receive speech therapy, physical therapy, and occupational therapy. Record contained a medical care provider's visit note dated 4/7/18 that documented physical therapy and occupational therapy continued to work with resident. Resident's NSA/HCSP did not specify resident received therapy services. Review of the medical care provider's written order dated 1/25/18 included blood sugar checks fasting and bedtime and fluid restriction of 1500 milliliters each 24-hour period. The April 2018 medication administration record documented blood sugar testing 4 times a day at 6:00 a.m., 11:00 a.m., 2:00 p.m., and 8:00 p.m. The NSA/HCSP lacked a description of blood sugar testing and the identity of the provider of the testing. The NSA/HCSP lacked documentation of fluid restriction and monitoring of resident's intake of fluid. Interview at 9:42 a.m. on 5/2/18, certified staff G stated staff checked resident's blood sugar 4 times a day and he/she tried to keep resident's floor free of clutter and made sure resident had walker and call pendant available. During an interview at 10:07 a.m. on 5/2/18, resident #251 stated he/she had fallen when getting up to bathroom or going into bathroom. Resident stated facility staff tested his/her blood sugar level and resident complained of sore fingers caused by pricking fingers for blood. During an interview at 1:05 p.m. on 5/2/18, licensed nurse C stated certified medication aides and licensed nurses performed glucometer testing to monitor resident's blood sugar 4 times a	S3155		

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S3155	Continued From page 7	S3155		

day. Licensed nurse C stated he/she did not follow medical care provider's order to check resident's blood sugar fasting and at bedtime. Licensed nurse C confirmed the NSA/HCSP lacked the service of blood sugar testing for resident by certified medication aides and licensed nurses. Licensed nurse C stated staff did not monitor resident's fluid intake.

At 1:34 p.m. on 5/2/18, when asked for interventions put in place to address resident's risk for falls, licensed nurse C stated resident's bed height had been lowered and resident received physical therapy and occupational therapy. Licensed nurse C confirmed resident's NSA/HCSP lacked interventions to address resident's risk for falls.

The operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #251 related to resident's falls and risk for falls and glucometer testing in accordance with the resident's functional capacity screen and negotiated service agreement.

- Record review on 5/1/18 for resident #250 revealed an admission date of 9/1/17 with diagnoses of arteriosclerotic heart disease, osteoarthritis, and dementia.

Functional capacity screens dated 9/1/17 and 2/28/18 each indicated resident required physical assistance with bathing and dressing; was independent with toileting, transferring, and mobility with a walker, experienced impaired short-term memory impairment; incontinent of urine; and was at risk for falls.

Negotiated service agreement/health care service

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S3155	Continued From page 8	S3155		

plans (NSA/HCSP) dated 9/1/17 and 2/28/18 each documented the following services:
Bathing assistance by an outside resource.
Dressing assistance by facility staff because resident could not lift right arm due to a permanent injury. If resident tries to use right arm it causes pain.
Toileting: resident independent with toileting and managed incontinence care independently.
Each NSA/HCSP documented resident required continuous supplemental oxygen due to shortness of breath.
Each NSA/HCSP lacked interventions to address resident's risk for falls.

Clinical notes contained the following entries:

10/30/17 at 11:18 a.m. licensed nurse C documented staff called at 2:30 a.m. to report resident slipped off side of bed when attempting to get into bed.

Note: NSA/HCSP lacked revision to include interventions to address resident's risk for falls.

12/6/17 at 2:58 p.m. licensed nurse H documented staff called to report resident called for assistance after falling. Resident stated he/she was walking to recliner, got feet tangled in oxygen tubing, and fell.

Note: NSA/HCSP lacked revision to include interventions to address resident's risk for falls.

12/15/17 at 2:35 p.m. licensed nurse C documented staff checked on resident at 1:25 p.m. and found on floor beside chair. Resident denied pain and no markings on skin.

Note: NSA/HCSP lacked revision to include

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S3155	Continued From page 9 interventions to address resident's risk for falls. Record contained a "Bed Device" assessment dated 2/28/18 completed by licensed nurse C for resident's use of a side rail (1/2 rail) attached to resident's bed. NSA/HCSP dated 2/28/18 lacked a description of resident's use of a side rail. During an interview at 2:55 p.m. on 5/1/18, resident stated that he/she had experienced falls. Resident stated that he/she had difficulty toileting self due to limited use of right arm and adjusting clothing. Resident stated he/she was incontinent of urine and to change incontinence brief he/she had to completely undress and dress lower body. Resident stated by the time he/she finished toileting and walked back to chair he/she was very short of breath and usually incontinent of urine again. Surveyor observed a half rail on each side of resident's bed. Interview at 9:48 a.m. on 5/2/18, certified staff G stated he/she assisted resident with dressing but that resident was independent with toileting. Certified staff G stated if resident called for assistance in bathroom certified staff did go assist resident as needed in bathroom. Certified staff G stated he/she made sure resident's floor was free of clutter and oxygen tubing out of way to help reduce risk for falls. During an interview at 1:56 p.m. on 5/2/18, licensed nurse C stated the (2/28/18) NSA/HCSP lacked a description of resident's use of a side rail for positioning and each NSA/HCSP lacked interventions to address resident's risk for falls. Licensed nurse C stated would reassess for needed assistance with toileting and incontinence management.	S3155		

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S3155	Continued From page 10 The operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #250 related to falls and risk for falls, toileting assistance, and use of a positioning device in accordance with the resident's functional capacity screen and negotiated service agreement. - Record review for resident #252 revealed an admission date of 6/6/17 with diagnoses of dementia, hypertension, and atrial fibrillation. Functional capacity screens dated 6/6/17 and 12/26/17 each indicated resident was independent with transferring self; required supervision with walking with walker and toileting; experienced impaired short-term memory, long-term memory, memory recall, and decision making; was at risk for falls; and exhibited wandering behavior. Negotiated service agreement/health care service plans (NSA/HCSP) dated 6/6/17 and 12/26/17 each lacked interventions to address resident's risk for falls and wandering behavior. The record contained a "Bed Device" assessment completed by licensed nurse C dated 5/1/18 that documented resident used a 1/4 side rail for assistance to get in and out of bed. At 11:30 a.m. on 5/1/18, surveyor observed resident #252 sitting at a table in the dining area. Resident asked staff and other residents to take him/her home. A staff person sat with resident for a while and encouraged resident to eat a snack. At 11:55 a.m. on 5/1/18, resident walked with walker and was accompanied by certified staff to resident's apartment.	S3155		

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S3155	Continued From page 11 During a confidential interview, a person reported resident (#252) entered other resident rooms uninvited. At 9:55 a.m. on 5/2/18, surveyor observed a1/4 rail attached to resident's bed. During an interview at 1:44 p.m. on 5/2/18, licensed nurse C stated resident used the 1/4 rail attached to bed to get in and out of bed and confirmed resident's NSA/HCSP lacked a description of resident's use of the device. Licensed nurse C stated supervision with activities of daily living as the only intervention to address resident's risk for falls. Licensed nurse C confirmed resident's NSA/HCSP lacked a description of services to address resident's wandering behavior and to keep resident safe. The operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #252 related to resident's wandering behavior, risk for falls, and use of a positioning device.	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 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	S3200		

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S3200	Continued From page 12 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 (#251) of 3 residents sampled, operator B failed to ensure medications were administered to the resident in accordance with a medical care provider's written order. Findings included: - Record review for resident #251 revealed an admission date of 1/26/18 with diagnoses of type 2 diabetes mellitus, neuropathy, congestive heart failure, dementia, and hypertension. Functional capacity screen dated 1/26/18 indicated resident required physical assistance with medication management. Negotiated service agreement/health care service plan dated 1/26/18 documented service of medication management and administration by licensed nurse and medication aides. Comparison of the April 2018 medication	S3200		

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S3200	Continued From page 13 administration record (MAR) and the written medical care provider's orders revealed the following discrepancies: Namzaric (dementia) 28 milligrams (mg)-10 mg 1 capsule by mouth daily, with order dated 1/25/18 to administer in the evening and entered on MAR to be administered between 6:00 a.m. and 10:00 a.m. Tramadol (pain reliever) 50 mg 1 tablet by mouth ordered on 1/25/18 to be administered 3 times a day and entered on MAR to be administered 4 times a day. Gabapentin (neuropathy) 100 mg 1 capsule by mouth ordered on 1/25/18 to be administered 2 times a day and entered on MAR to be administered 3 times a day. Senna-S (stool softener/laxative) ordered 1/25/18 for 2 tablets by mouth 2 times a day and entered on MAR as 1 tablet by mouth 1 time a day. At 1:05 p.m. on 5/2/18, licensed nurse C stated resident did not receive the above medications as ordered. Operator B failed to ensure medications were administered to resident #251 in accordance with a medical care provider's written order.	S3200		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy	S3215		

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(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
S3215	Continued From page 14 provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)(1) The facility reported a census of 22 residents. The sample included 3 residents. Based on observation and interview for 1 (#250) of 3 residents sampled, licensed nurses and medication aides failed to store a controlled medication in a refrigerator in a locked	S3215		

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	N040008	A. BUILDING: _____ B. WING _____	05/07/2018

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S3215	Continued From page 15 compartment within a locked medication room in accordance with federal and state laws and regulations. Based on observation and interview for 1 (#253) non-sampled resident, licensed nurses and medication aides failed to store a medication according to manufacturer and pharmacy recommendations. Findings included: - At 11:10 a.m. on 5/2/18, along with certified medication aide (CMA) D, surveyor observed a bottle of liquid lorazepam (anti-anxiety), a controlled medication, for resident #250 in an unlocked refrigerator in a locked medication room. CMA D stated the refrigerator did not have a lock. CMA D unlocked a cabinet in the medication room and removed a tray of controlled medications. Surveyor observed a box containing a bottle of liquid lorazepam with a pharmacy label with resident #253's name and fill date of 3/28/18. The medication box also contained a "refrigerate " label to indicate medication to be stored in a refrigerator and not at room temperature. Licensed nurses and medication aides failed to store a controlled medication in separately locked compartments within a locked medication room and failed to store a medication according to manufacturer and pharmacy recommendations.	S3215		
S3216 SS=E	26-41-205 (i) Disposition of Medication (i) Accountability and disposition of medications.	S3216		

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S3216	Continued From page 16 Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(i) The facility reported a census of 22 residents. The sample included 3 residents. Based on record review, observation, and interview for 2 (#250 and #251) of 3 residents sampled and 5 (#253, #254, #255, #256, and #257) non-sampled residents, licensed nurses and medication aides failed to ensure records were maintained of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation.	S3216		

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S3216	Continued From page 17 Findings included: - Review of the resident roster revealed the facility managed medications for each of the 22 residents listed. At 11:10 a.m. on 5/2/18, certified medication aide (CMA) D unlocked the medication room and surveyor opened the medication refrigerator and observed medications and biologicals that CMA D stated residents no longer received. Surveyor and CMA D placed these discontinued/outdated medications and biologicals in a plastic tray to take to licensed nurse C. CMA D unlocked a cabinet and removed a tray that held 3 boxes with each box containing a bottle of 30 milliliters of liquid morphine (a controlled medication for pain relief) with pharmacy label for resident #250 and one box containing a bottle of liquid lorazepam (a controlled medication for anxiety) for resident #253. Surveyor asked CMA D if these controlled medications were accounted for each time medication keys were passed from one CMA or licensed nurse to another and CMA stated "No." At 11:30 a.m. along with licensed nurse E, licensed nurse C, and regional vice-president F, surveyor removed the medications and biologicals that were removed from medication refrigerator: Plastic cup with name of resident #251 that held 8 syringes filled with an unidentified substance. Licensed nurse C stated these were syringes he/she prefilled with insulin for resident #251 to receive. Licensed nurse C could not provide a date filled and confirmed resident received insulin with an insulin pen.	S3216		

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S3216	Continued From page 18 Novolin insulin one open vial labeled for resident #251. The vial lacked a date to indicate when the vial was opened. A plastic bag with 4 unopened vials of insulin and 8 opened vials of insulin labeled for resident #255. Licensed nurse C stated resident brought these insulin vials on admission to facility and confirmed resident received insulin with an insulin pen. Resident #256 (deceased 4/27/18) one insulin pen and 6 acetaminophen suppositories. Resident #254 with 2 opened vials of insulin and 2 unopened vials. Licensed nurse C confirmed resident received insulin with an insulin pen. Resident #257 (no longer living in facility) one vial of cyanocobalamin (injectable synthetic vitamin B12). Aplisol (solution used in tuberculosis skin testing) no date to indicate when vial opened. Influenza vaccine without a date to indicate when vial opened. Six acetaminophen suppositories without resident identification. Licensed nurse C and licensed nurse D confirmed these medications needed to be destroyed and documented as destroyed. Licensed nurse C stated CMAs and licensed nurses were to account for all controlled medications with every shift change. Licensed nurses and medication aides failed to ensure records were maintained of the receipt and disposition of all medications managed by	S3216		

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S3216	Continued From page 19 the facility in sufficient detail for an accurate reconciliation.	S3216		
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) The facility reported a census of 22 residents. The sample included 3 residents. Based on interview and record review for all residents. operator B 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 10:00 a.m. on 5/1/18 with licensed nurse C and operator B, licensed nurse C stated a staffing pattern of 2 certified staff on duty during each of the 3 shifts. Operator B provided documentation of an emergency drill with evacuation of residents dated 7/30/17 with 3 employees assisting a total of 12 residents to evacuate building in 3 minutes and 52 seconds. During a confidential interview a person reported	S3265		

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S3265	Continued From page 20	S3265		

nursing hours were shortened and facility staffing pattern of 1 certified staff on evening shift (2:00 p.m. to 10:00 p.m.) and one certified staff on night shift (10:00 p.m. to 6:00 a.m.) instead of 2 certified staff working these shifts.

At 4:10 p.m. on 5/1/18, operator B confirmed there had been a reduction in certified staff hours. Operator B stated he/she was informed by (regional vice-president F) on 4/18/18 to decrease to 1 certified staff on 2:00 p.m. to 10:00 p.m. shift and on the 10:00 p.m. to 6:00 a.m. shift. Operator B stated he/she did not conduct an emergency drill with one staff member evacuating all residents to a safe place,

During an interview at 9:32 a.m. on 5/2/18, regional vice-president F stated he/she contacted (operator B) on 4/3/18 regarding a workforce reduction of on the days licensed nurse C here to have 1 certified staff work from 6:00 a.m. to 2:00 p.m. and 1 certified staff to work 4 hours since licensed nurse C would be the second person on duty. Regional vice-president F stated 2 staff were to continue to be in the in the building on the 2:00 p.m. to 10:00 p.m. shift and the 10:00 p.m. to 6:00 a.m. shift and "we know we need 2 people for evacuation." Regional vice-president F stated there was a communication error between (operator B) and him/her. Regional vice-president F stated the staffing pattern had been corrected as of yesterday.

Review of the resident roster revealed 13 of the 22 residents experienced impaired cognition.

Record review for resident #250 revealed an admission date of 9/1/17 with diagnoses of arteriosclerotic heart disease. The negotiated service agreement/health care service plan dated

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S3265	Continued From page 21 2/28/18 specified in the event of an emergency evacuation resident would need staff assistance. During an interview at 2:55 p.m. on 5/1/18, resident #250 stated he/she required use of a wheelchair and could not mobilize self in wheelchair. Surveyor observed resident with supplemental oxygen through a concentrator and would require to be changed over to an oxygen tank to evacuate to a safe place. Record review for resident #252 revealed an admission date of 6/6/17 with diagnoses of dementia, hypertension, and atrial fibrillation. Functional capacity screen dated 12/26/17 indicated resident experienced impaired short-term memory, long-term memory, memory recall, and decision making and required supervision of mobility with walker. The negotiated service agreement/health care service plan dated 12/26/17 documented resident required cueing and constant reminders and would require staff assistance during an emergency evacuation. For all residents. operator B 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		