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	N070008	A. BUILDING: _____ B. WING _____	02/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE RETIREMENT COMMUNITY ASSISTED L	702 W 7TH PO BOX 308 OVERBROOK, KS 66524

(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 an resurvey with a complaint (#120038) at the above named assisted living facility conducted on 1/31/18, 2/1/18 and 2/5/18.	S 000		
S3030 SS=F	26-41-101 (g) Availability of Policies and Procedures (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (g) The facility reported a census of 19 residents. Based on observation and interview the facility failed to post a notice of availability of policies and procedures related to resident services. Findings included: - Observations during initial tour on 1/31/18 at 8:50 AM lacked evidence of the posting of availability of policies and procedures related to resident services. During an interview on 2/1/18 at 8:00 AM administrative staff A reported the facility did not have a posting up as to the availability of policies and procedures related to resident services.	S3030		

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

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S3030	Continued From page 1 The facility failed to post a notice of availability of the policies and procedures related to resident services.	S3030		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility 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 26-41-201 (c) (1) The facility reported a census of 19 residents. The sample included 3 residents and 1 closed record. Based on record review and interview, the Administrator failed to ensure that designated facility staff conducted a screening to determine the functional capacity for 1 (#111) of 4 residents. Findings included: - Review of record revealed #111 admitted to facility 4/25/15 with diagnosis of Hypertension, constipation, hypothyroidism, history of falls and history of fractured ileum. Review of the functional capacity screen (CS)	S3081		

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S3081	Continued From page 2 dated 4/27/15 revealed the resident needed supervision with bathing and physical assistance with management of medications and treatments. Review of the resident's record lacked evidence of at least annual FCS. An interview on 1/31/18 at 11:50 AM administrative nursing staff B confirmed the resident had not had a FCS since admission. (4/25/15) Review of the undated FCS policy revealed designated facility staff shall conduct a screening to determine each resident's functional capacity at least once every 365 days. The Administrator failed to ensure that designated facility staff conduct a screening to determine resident's functional capacity at least every 365 days.	S3081		
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;	S3085		

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S3085	Continued From page 3 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 19 residents. The sample included 3 residents and 1 closed record. Based on record review and interview, the Administrator failed to ensure that designated facility staff completed the Negotiated Service Agreement to include a description of the outside services the resident received, identification of the provider of each service, and identification of the party responsible for payment of the outside service for 3 (#112, #113, #114) of 4 residents. Findings included: - Review of resident #112's record revealed he/she admitted to the facility on 12/2/16 with diagnosis of Parkinson's, chronic pain, anxiety disorder, hypertension and osteoarthritis. Review of the functional capacity screen dated 12/2/16 revealed the resident required physical assistance with management of medications and treatments and with bladder incontinence. Review of the Negotiated Service Agreement dated 12/2/16 revealed the resident required assistance with toileting, incontinence assistance, mobility, Am and PM dressing/grooming assistance, assistance with personal laundry and linens and assistance with management of medications. The NSA failed to identify the	S3085		

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S3085	Continued From page 4	S3085		

resident received Hospice services and exactly what services Hospice provided and who paid for the service.

Review of the nurse's notes dated 12/2/16 revealed the resident admitted to the facility and received Hospice services due to Parkinson's disease.

Review of the signed physician's hospice orders dated 12/7/16 revealed to admit the resident to assisted living facility.

Review of a physician's order dated 1/18/17 revealed the resident discontinued Hospice services on 1/14/17.

During an interview on 1/31/18 at 3:40 PM administrative nursing staff B confirmed Hospice services should have been on the Negotiated Service Agreement upon admission to the facility.

The facility failed to ensure delegated staff completed the Negotiated Service Agreement to include the appropriate information regarding outside services.

- Record review for Resident #113 revealed admission on 12-10-16 with diagnoses Hyperlipidemia, Hypothyroidism, Neuropathy, Rash, Non-pressure Chronic Ulcer Right Foot, Urinary Retention, Low Back Pain, Gout and Diverticulosis.

The Functional Capacity Screen dated 12-30-16 recorded resident required physical assistance with bathing and management of medications; supervision of dressing; independent with toileting, transfers, walking/mobility, eating and management of treatments. No problems with

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S3085	Continued From page 5	S3085		

cognition or communication. No problems/risks identified.

The Negotiated Service Agreement dated 12-30-16 under section for "Personal Care" with check mark for resident to receive assistance with bathing/showering. Under section for "Medication Management" check mark that resident "requires assistance". The NSA lacked identification of the pharmacy provider, podiatry provider, and the home health provider including a description of services the home health agency was to provide. The NSA further lacked identification of each party responsible for payment of these outside providers.

The record contained documentation of a podiatrist visit on 11-28-17.

The record contained a signed physician order for "Physical Therapy/Occupational Therapy to evaluate and treat for diagnosis of weakness" on 1-13-17 with documentation that resident was discharged from physical therapy and occupational therapy on 8-10-17.

Interview on 2-5-18 at 11:16 am with Licensed Nursing Staff B confirmed the NSA lacked identification of the pharmacy provider, podiatry provider, and identification of a home health agency to provide physical and occupational therapy. Further confirmed the NSA lacked identification of each party responsible to pay the outside providers.

- Record review for Resident #114 revealed admission on 1-15-18 with diagnoses Dementia without Behavioral Disturbance, Chronic Kidney Disease Stage #3, Hypertension and Low Back

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S3085	Continued From page 6 Pain. The Functional Capacity Screen Dated 1-16-18 recorded resident required supervision of bathing. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. The Negotiated Service Agreement dated 1-16-18 under section for "Personal Care" with check mark for resident to receive assistance with bathing/showering. Under section for "Medication Management" check mark that resident "requires assistance". The NSA lacked identification of the pharmacy provider and identification of each party responsible for payment of the pharmacy provider. Interview on 2-1-18 at 12:15 PM with Licensed Nursing Staff B confirmed the NSA lacked identification of the pharmacy provider and each party responsible for payment of the pharmacy provider. Facility policy for "Negotiated Service Agreement" stated the administrator ...shall ensure the development of a written negotiated service agreement for each resident ...the negotiated service agreement shall provide ...a description of the services the resident will receive; identification of the provider of each service if outside resources provide a service; and identification of each party responsible for payment if outside resources provide a service. For Resident's #112, #113, #114, the administrator failed to ensure the negotiated service agreement a description of services the residents were to receive; identification of the providers of these services if outside resources	S3085		

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S3085	Continued From page 7 provide the services; and identification of each party responsible for payment of the outside resources.	S3085		
S3156 SS=F	26-41-204 (b) Health Care Services (b) If the functional capacity screening indicates that a resident is in need of health care services, a licensed nurse, in collaboration with the resident, the resident ' s legal representative, the case manager, and, if agreed to by the resident or resident ' s legal representative, the resident ' s family, shall develop a health care service plan to be included as part of the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (b) The facility reported a census of 19 residents. The sample included 3 residents and 1 closed record. Based on record review and interview for all residents, the Administrator failed to ensure that designated facility staff developed a health care service plan as part of the negotiated service agreement as evidenced by 3 of 4 residents (#111, #112, #113). Findings included: - Review of record revealed #111 admitted to facility 4/25/15 with diagnosis of Hypertension, constipation, hypothyroidism, history of falls and history of fractured ileum.	S3156		

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S3156	Continued From page 8 Review of the functional capacity screen (FCS) dated 4/27/15 revealed the resident needed supervision with bathing and physical assistance with management of medications and treatments. Review of the Negotiated Service Agreement/health care service plan(NSA/HCSP) dated 4/12/17 identified the resident required assistance with bathing/showering, management of medications, and assistance to launder linens. The NSA/HCSP failed to identify what kind of assistance the staff needed to provide for the resident. Review of the nurse's notes revealed the following: On 1/18/18 the resident needed to be encouraged to remain immobile as much as possible that night, needed to have arm wrapped and splinted to prevent further dislocation of elbow. 1/21/18 the residents right arm remained in splint. Review of the NSA/HCSP lacked a health service plan to direct staff as to the care they needed to provide while the resident wore a splint. An interview on 1/31/18 at 7:35 AM certified staff C reported he/she did not think the assisted living had any kind of care plans. An interview on 1/31/18 at 12:15 PM administrative nursing staff B reported he/she did not have specific health service plans that directed staff as to the specific type of assistance staff needed to provide the resident. The administrator failed to ensure designated staff developed a health care service plan as part	S3156		

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S3156	Continued From page 9 of the negotiated service agreement. - Review of resident #112's record revealed he/she admitted to the facility on 12/2/16 with diagnosis of Parkinson's, chronic pain, anxiety disorder, hypertension and osteoarthritis. Review of the functional capacity screen dated 12/2/16 revealed the resident required physical assistance with management of medications and treatments and with bladder incontinence. Review of the NSA/HCSP dated 12/2/16 revealed the resident required assistance with toileting, incontinence assistance, mobility, Am and PM dressing/grooming assistance, assistance with personal laundry and linens and assistance with management of medications. The NSA/HCSP failed to identify the type of assistance the resident required for the above health care services. Review of the nurse's notes revealed the following: On 3/13/17 the resident required use of a wheelchair for breakfast and assistance of 1 staff for transfers and dressing. On 8/15/17 the resident had a decline in capabilities and required a lot of physical assistance at night to get in bed. On 8/21/17 the resident required physical assistance of 1 staff with toileting every 1 hour as well as physical assistance with all transfers to and from wheelchair due to unable to use the walker. The NSA/HCSP failed to identify the decline in functional capabilities to direct staff to provide the necessary health care services.	S3156		

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S3156	Continued From page 10 An interview on 1/31/18 at 7:35 AM certified staff C reported he/she did not think the assisted living had any kind of care plans An interview on 1/31/18 at 12:15 PM administrative nursing staff B reported he/she did not have specific health service plans that directed staff as to the specific type of assistance staff needed to provide the resident. The administrator failed to ensure designated staff developed a health care service plan as part of the negotiated service agreement. - Record review for Resident #113 revealed admission on 12-10-16 with diagnoses Hyperlipidemia, Hypothyroidism, Neuropathy, Rash, Non-pressure Chronic Ulcer Right Foot, Urinary Retention, Low Back Pain, Gout and Diverticulosis. The Functional Capacity Screen dated 12-28-17 recorded resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility and management of medications/treatments; independent with eating. No problems with cognition or communication. No problems/risks identified. The Negotiated Service Agreement dated 12-28-17 under section for "Personal Care" with check marks for resident to receive assistance with bathing/showering, toileting, incontinence, mobility, transferring and dressing in AM and PM. Under section for "Medication Management" checked that resident "requires assistance". The NSA lacked documentation of a health care service plan for the indicated services. Wound Care Center documentation for a visit on	S3156		

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S3156	Continued From page 11 1-17-18 stated: "Right outside foot: Iodoflex gauze and conform (bandage). Change every 3 to 4 days. Soap and water wash with dressing change. Keep dressing on and dry during shower to avoid getting dirty water in ulcer. Avoid pressure and friction to this area by keeping covers loose and wearing house slipper during the day and off-loading boot at night. Buttocks: if area remains open continue to apply zinc daily (after toileting, showering, etc). Do not scrub off during bath, it is meant to provide a thick protective barrier." Observation of Resident #113 on 1-31-18 at 1:38 PM revealed an alert and oriented times 3 resident sitting on toilet with wheelchair in front of him/her. Certified Staff C answered resident's call light. Certified Staff C performed pericare. Resident's groin had a red inflamed rash with areas of serous drainage. Resident's buttocks were dark red with sluggish blanching of skin; right buttock had an open area measuring approximately 2.5 cm (centimeters) in diameter and left buttock with 2 small areas which appeared to be open measuring approximately 1 cm in diameter. Certified Staff C removed a barrier dressing which was coming off and applied a barrier cream to the areas. Certified Staff C confirmed he/she also administered resident's medications. Certified Staff C emptied urine from a bag attached to the resident's leg, changed brief (which required a great deal of encouragement from staff) and assisted resident with pulling up and rearranging clothing. Staff C then assisted with transfer into wheelchair while resident stood, held onto grab bar and was able to pivot into the wheelchair. Certified Staff C pushed resident to his/her recliner and assisted with transferring resident into the recliner.	S3156		

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S3156	Continued From page 12 Interview on 1-31-18 at 1:38 PM with Resident #113 confirmed the staff "do most everything for me" which included assisting with bathing, dressing, toileting, transfers and administration of medication. Stated he/she was able at times to transfer self to the toilet sometimes, but required assistance with hygiene and getting back into wheelchair. Interview on 1-31-18 at 12:15 PM with Administrative Nurse B confirmed Resident #113 went to the wound care center for treatment of open areas on right foot and buttocks. Stated instructions for wound care were all on the resident's Medication Administration Record. Confirmed the NSA lacked documentation of a health care service plan regarding the potential for and actual skin care impairment, catheter care, instructions for bathing, dressing, transfers and mobility. For Resident #113, the administrator failed to ensure the licensed nurse developed a health care service plan to be included as part of the negotiated service agreement which addressed resident's skin impairment, catheter care, transfer and mobility assistance, and instructions for bathing and dressing.	S3156		
S3166 SS=E	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S3166		

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S3166	Continued From page 13 This REQUIREMENT is not met as evidenced by: KAR-26-41-204 (e) The facility reported a census of 19 residents. Based on record review of 3 of 3 certified medication aide employee files and interview the administrator failed to delegate the nursing procedure of blood sugar monitoring to each certified medication aide under the Kansas nurse practice act, K.S.A.65-1124 and amendments thereto. Findings included: Review of employee records revealed certified staff C, F, and G did not have evidence of licensed nurse delegation for blood glucose testing which is not part of the certified medication aide curriculum. During an interview on 1/31/18 at approximately 10:00 AM administrative nursing staff B reported the licensed nurses administer resident's insulin, some residents do their own blood sugar checks and the certified medication aides to the other blood sugar checks. During an interview on 2/1/18 at 9:52 AM administrative nursing staff B reported he/she did not have delegation checks for the certified medication aides to provide the nursing procedure of blood glucose testing. The administrator failed to ensure delegated staff ensured certified medications were properly trained on completion of blood glucose testing which is a nursing procedure.	S3166		

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S3200	Continued From page 14	S3200		
S3200 SS=E	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 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 19 residents. The sample included 3 residents and 1 closed record review. Based on record reviews and interviews for 3 (#112, #113, #114) of 3 sampled residents whose medications are managed by the facility, the administrator failed to ensure all medications and biologicals are administered to the residents in accordance with a medical care providers written order and professional standards of practice.. Findings included:	S3200		

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BROOKSIDE RETIREMENT COMMUNITY ASSISTED L	702 W 7TH PO BOX 308 OVERBROOK, KS 66524

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S3200	Continued From page 15 - Review of resident #112's record revealed he/she admitted to the facility on 12/2/16 with diagnosis of Parkinson's, chronic pain, anxiety disorder, hypertension and osteoarthritis. Review of the functional capacity screen dated 12/2/16 revealed the resident required physical assistance with management of medications and treatments and with bladder incontinence. Review of the NSA/HCSP dated 12/2/16 revealed the resident required assistance with management of medications. Review of the resident's medication administration record from 7/17/17 to 8/25/17 revealed the resident missed the following doses of Pramipexole (a Parkinson's medication): 4-7 PM dose on 7/28/17 and 7/29/17; the 8-10 PM dose on 8/6/17 and 8/12/17. The medication administration record lacked specifics as to why the medication was not administered. During an interview on 2/1/18 at 9:50 AM administrative nursing staff B confirmed the resident missed 4 doses of the Pramipexole and did not have an explanation for the missed doses. The administrator failed to ensure certified staff followed professional standards of care and administered medications according to physician orders. - Record review for Resident #113 revealed admission on 12-10-16 with diagnoses Hyperlipidemia, Hypothyroidism, Neuropathy, Rash, Non-pressure Chronic Ulcer Right Foot, Urinary Retention, Low Back Pain, Gout and Diverticulosis.	S3200		

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S3200	Continued From page 16 The Functional Capacity Screen dated 12-28-17 recorded resident required physical assistance with management of medications and treatments. The Negotiated Service Agreement dated 12-28-17 under section for "Medication Management" check mark that resident "requires assistance". Review of Medication Administration Record (MAR) for January 2018 and physician orders revealed the following discrepancies: - MAR stated Albuterol sulfate solution for nebulization 2.5 mg (milligrams) per 3 ml (milliliters). Administer 1 vial every 4 hours by inhalation as needed. The medication lacked documentation of a written order from a medical care provider. Interview on 2-1-18 at 9:56 AM with Licensed Nursing Staff B confirmed the Albuterol breathing treatment lacked a written physician's order. - MAR stated Synthroid (levothyroxine) tablet (Hypothyroidism) 100 mcg (micrograms) Administer 1 tablet orally once a day. Physician order dated 12-18-17 and noted by Licensed Nursing Staff B stated Levothyroxine 112 mcg by mouth every morning before breakfast. The record lacked documentation of a written order from the medical care provider for the decreased dose of 100 mcg. Interview on 2-1-18 at 9:59 AM with Licensed Nursing Staff B stated Resident #113 was seen by medical care provider on 1-31-18 and the physician stated he/she was decreasing the dose of the levothyroxine at that time. Stated he/she failed to document this as a verbal order at the time the physician made the change per	S3200		

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S3200	Continued From page 17	S3200		

standards of practice and confirmed the record lacked documentation of this change in dosage.

For Resident #113, the administrator failed to ensure the resident's medications were administered in accordance with a medical care provider's written order and standards of practice.

- Record review for Resident #114 revealed admission on 1-15-18 with diagnoses Dementia without Behavioral Disturbance, Chronic Kidney Disease Stage #3, Hypertension and Low Back Pain.

The Functional Capacity Screen Dated 1-16-18 recorded resident independent with management of medications and treatments. The Negotiated Service Agreement dated 1-16-18 under section for "Medication Management" check mark that resident "requires assistance".

Review of Medication Administration Record (MAR) for January 2018 and physician orders revealed the following discrepancies:
- MAR stated Prednisone (steroid) tablet 20 mg (milligrams) Administer 2 tablets orally once a day for 5 days. The record lacked documentation of a medical care provider's written order for the medication.

Interview on 2-1-18 at 4:23 PM with Licensed Nursing Staff B confirmed the record lacked documentation of a written order for the medication. Stated resident was seen by physician on 1-25-18 and physician stated would try prednisone 40 mg confirmed he/she failed to document this as a verbal order for the record per standards of practice. Physician's office faxed a history and physical for the resident which

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S3200	Continued From page 18 documented along with other changes, "Prednisone 40 mg daily for next four days." For Resident #114, the administrator failed to ensure the resident's medications were administered in accordance with a medical care provider's written order and standards of practice.	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 19 residents. The sample included 3 residents and 1 closed record review. Based on observation and interview, the licensed nurse failed to ensure over the counter medications shall be labeled with the resident's full name. Findings included:	S3211		

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S3211	Continued From page 19 - Observation during tour accompanied by Licensed Nursing Staff B on 1-31-18 at 9:00 AM of medication room, revealed a locked drawer with the following open bottles of over the counter medications: Clear Lax (laxative) labeled as opened October 2017. Ibuprofen (pain/fever reliever) 200 mg (milligrams) opened 11-11-17. Milk of Magnesia (laxative) opened 11-12-17. Iron tablets (supplement) 325 mg Loperamide (anti-diarrheal) 2 mg opened December 2017. Loratidine (allergy relief) 10 mg opened 9-2-17. Acetaminophen (pain/fever relief) 325 mg liquigels opened November 2017. The cabinet also contained 2 unopened bottles of Stool Softener (docusate sodium) 100 mg. Interview on 1-31-18 at 9:00 AM with Licensed Nursing Staff B stated the above bottles of medications were "stock medications" and were used for any resident who had an order but did not have their own medication and did not realize facility could not have stock medications. Confirmed the over the counter medications lacked resident names. Facility policy for "Storage of Medications" and "Medication Management" lacked procedures for management of over the counter medications. The licensed nurse failed to ensure all over the counter medications were labeled with the resident's full name.	S3211		

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S3280	Continued From page 20	S3280		
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. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 19. The sample included 3 residents and 1 closed record review. Based on record review and interview for all residents and all facility employees, the administrator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with employees and residents. Findings included: - Review on 2-1-18 at 8:37 AM of the facility's	S3280		

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S3280	Continued From page 21 emergency management plan revealed documentation of review performed with residents in Resident Council on 4-1-16 and 4-3-17. Documentation of review with employees performed on 4-14-16 and 5-25-17. Facility unable to provide any further documentation of review with residents and employees. The plan lacked documentation of quarterly review with all residents and all employees. Interview on 2-1-18 at 9:15 am with Administrative Staff A confirmed the facility lacked documentation of quarterly review of the emergency management plan with all staff and residents. Confirmed no system in place for review of the emergency plan with residents who do not attend resident council. The facility policy for "Disaster and Emergency Preparedness" stated each administrator shall ensure emergency preparedness by ensuring the performance of quarterly review of the facility's emergency management plan with employees and residents. The administrator failed to follow facility policy. For all residents and employees, the administrator failed to ensure emergency preparedness by ensuring quarterly review of the emergency management plan with all staff and residents.	S3280		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be	S3298		

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S3298	Continued From page 22 served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility reported a census of 19 residents. The sample included 3 residents and one closed record review. The administrator failed to ensure food shall be prepared using safe methods that conserve the nutritive value, flavor and appearance and shall be served at the proper temperature as evidenced by observation and interview and affecting all residents. Findings included: - Observation/Interview during entrance tour on 1-31-18 at 9:37 AM of facility kitchen revealed Dietary Staff D making breakfast to order for residents. Dietary Staff E stated breakfast is cooked to order in this kitchen; lunch and dinner are cooked in the "main kitchen" (in another building) and brought over on a hot cart. Stated	S3298		

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S3298	Continued From page 23	S3298		

"we temp it and put it in (the steam table). Requested food temperature logs.

- Review of the logs for January 2018 revealed the following dates/meals lacked documentation of food temperatures:
January 2018: 1-1 (lunch, dinner meat only); 1-5 (dinner); 1-6 (lunch, dinner); 1-8 (breakfast, lunch); 1-10 (dinner); 1-12 (dinner); 1-14 (breakfast, lunch, dinner); 1-15 (lunch, dinner); 1-16 (lunch); 1-17 (dinner); 1-18 (dinner); 1-19 (dinner); 1-20 (dinner); 1-21 (lunch, dinner); 1-23 (dinner); 1-24 (dinner); 1-25 (breakfast, dinner); 1-26 (dinner); 1-30 (dinner).

Interview on 1-31-18 at 9:40 AM with Dietary Staff E reviewed the food temperature logs and confirmed the logs were incomplete.

Observation of Dietary Staff E preparing for lunch on 2-1-18 around 11:55 AM revealed the following menu with temperatures:
Hot cart brought from main kitchen with stainless steel serving pans. The foil-covered pans were transferred from cart by Dietary Staff E and placed on the steam table.
Gravy 160 degrees F (Fahrenheit)
Turkey 165 degrees F
Mashed Potatoes 125 degrees F (removed from steam table and place in 350 degree F oven to bring up to serving temperature of at least 140 degrees F).
Green Beans 160 degrees F
Sausage and Potato Soup 150 degrees F

Review of Resident Council Minutes for 11-2-17 documented resident concern: "Food not hot enough"; and for 12-6-17 stated, "Food not hot enough. Talked to cooks." Current concern: "coffee not hot enough."

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S3298	Continued From page 24 "Guidelines" for dietary staff on refrigerator stated, "Make sure you are temping the food before service! One of the biggest complaints is that the food is being served cold and we all know that this is unacceptable. Please either use the steam table or oven to hold the food temperatures. We will continue to serve (lunch/supper) as we (always have) in the past: Check the food temperatures to make sure they are at serving ready temperatures." Guidelines for proper temperature ranges posted in kitchen. For all residents, the administrator failed to ensure food shall be served at the proper temperature.	S3298		
S3310 SS=D	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by:	S3310		

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S3310	Continued From page 25 KAR 26-41-207(c) The facility reported a census of 19 residents. The sample included 3 residents and 1 closed record review. Based on record review and interview for 1 (#113) of 3 sampled residents the administrator failed to ensure the home's compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Resident record review for Resident #113 revealed admission on 12-10-16. The record lacked documentation of a two-step TB skin test and or a chest x-ray to rule out TB and a TB symptom questionnaire. Interview on 1-31-18 at 12:57 PM with Licensed Nursing Staff B confirmed the record lacked documentation of a 2-step TB skin test or chest x-ray to rule out TB or TB symptom screen questionnaire. Facility policy stated: "Screening New Admissions or Readmissions: a. The facility will screen referrals for admission for information regarding exposure to, or symptoms of TB and will check results of any recent Mantoux skin tests or chest x-rays. c. A nurse will administer the Mantoux skin test to all new admissions or readmissions whose TB exposure status us unknown or questionable. The facility failed to follow their policy. For Resident #113, the administrator failed to ensure the home's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R.	S3310		

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S3310	Continued From page 26 26-39-105.	S3310		
S3320 SS=F	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254 (a) The facility reported a census of 19 residents. Based on observation and interview the administrator failed to ensure staff secured all chemicals to maintain the safety of all residents. Findings included:	S3320		

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S3320	Continued From page 27 - Observation on 1/31/18 at 9:32 AM revealed the kitchen cabinet under the sink unlocked. The cabinet contained the following chemicals: H-101 sanitizer, ultra de-lime solution, an open gallon of Sans - spot without a lid connected to the dishwasher, a partial gallon of germicidal bleach, hand washing detergent with warning to keep out of reach of children and a spray can of oven grill fry cleaner. An Interview at 9:40 AM dietary staff E reported the doors to the kitchen are always open so the resident's and staff had access to the kitchen at all times. Review of the chemical storage policy dated 4/2006 revealed chemicals labeled "keep out of reach of children" shall be kept in locked cabinets and/or closets. The administrator failed to ensure delegated staff kept chemicals locked for resident safety.	S3320		