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	N087054	A. BUILDING: _____ B. WING _____	C 09/07/2017

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BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH WICHITA, KS 67206

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with investigation of complaint #115220 of the above assisted living facility on 8/28/17, 8/29/17, 8/30/17, 9/5/17, 9/6/17, and 9/7/17.	S 000		
S 110 SS=E	26-39-103 (c) NOTICE OF RIGHTS AND SERVICES (c) Notice of rights and services. (1) Before admission, the administrator or operator shall ensure that each resident or the resident's legal representative is informed, both orally and in writing, of the following in a language the resident or the resident ' s legal representative understands: (A) The rights of the resident; (B) the rules governing resident conduct and responsibility; (C) the current rate for the level of care and services to be provided; and (D) if applicable, any additional fees that will be charged for optional services. (2) The administrator or operator shall ensure that each resident or the resident ' s legal representative is notified in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care. This STANDARD is not met as evidenced by: KAR 26-39-103(c)(2) The facility reported a census of 37 residents. The sample included 3 residents. Based on record review and interview for 2 (#111 and #112) of 3 residents sampled, the operator failed to	S 110		

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

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S 110	Continued From page 1 ensure each resident's legal representative was notified in writing of any changes in charges that occurred after admission and at least 30 days before the effective date of the change. Findings included: - Record review for resident #111 revealed an admission date of 5/8/12. - Record review for resident #112 revealed an admission date of 7/6/12. At 11:30 a.m. on 8/30/17, operator B stated each resident had a rate increase effective 1/1/17 but he/she did not maintain a copy of the letter sent to notify family member of increase in order to show notification 30 days prior to the increase. The operator failed to ensure each resident's legal representative was notified in writing of any changes in charges that occurred after admission and at least 30 days before the effective date of the change.	S 110		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation.	S3026		

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S3026	Continued From page 2 This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(A)(B) The facility reported a census of 37 residents. The sample included 3 residents and 3 residents focus reviewed. Based on record review, observations, and interviews for 1 (#111) of 3 residents sampled, the operator failed to ensure no resident was subjected to neglect when licensed nurses failed to provide and coordinate services to address resident's choking risk, when staff neglected to serve pork ground per diet order and resident choked, and when staff failed to monitor resident's behavior to ensure he/she did not take thin liquids or foods that posed a choking risk from other residents. This failure placed resident #111 in immediate jeopardy for harm, injury, and/or death. Based on record review, observation, and interview for 1 (#112) of 3 residents sampled, the operator failed to ensure no resident was subjected to abuse and neglect when resident #112 requested to be placed on toilet and was told by staff member to urinate in brief and when facility staff failed to monitor resident #112 for coughing and choking while eating. Findings included: - Record review for resident #111 revealed an admission date of 5/8/12 and diagnoses of progressive cognitive decline and dysphagia. Functional capacity screen (FCS) dated 9/7/16 indicated resident required physical assistance with eating, independent with walking, and experienced impaired short-term memory, long-term memory, memory recall, and decision making ability.	S3026		

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S3026	Continued From page 3 Negotiated service agreement/health care service plan (NSA/HCSP) dated 9/7/16 documented nutrition service of "When possible resident is one of the first to be served for meals, to avoid (resident) leaving dining room without eating. Once served is able to feed (self). Resident at times needs redirection at meals as (resident) gets up and walks away without eating. . . .Regular diet and foods cut up in kitchen. A licensed nurse documented on 3/7/17 (no time entry documented) certified medication aide notified this nurse that resident choking. Abdominal thrusts performed on resident until throat cleared. No signs/symptoms of shortness of air after blockage cleared. Medical care provider and durable power of attorney notified. Licensed nurse documented at 11:00 a.m. on 3/8/17 that medical care provider evaluated resident, ordered speech therapy. Medical care provider documented on 3/8/17, resident being seen today for follow up of choking episode and weight loss. Nursing staff report resident choked during supper yesterday evening and had to administer Heimlich maneuver to clear resident ' s airway. Staff report resident has been eating today without difficulty. Dysphagia plan to have speech therapy evaluation. [Note: record did not contain documentation of the results of the evaluation and was not provided when requested.] Licensed nurse documented on 3/8/17 at 4:00 p.m. speech therapist evaluated resident and changed diet to mechanical soft with nectar thick liquids.	S3026		

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S3026	Continued From page 4 The NSA/HCSP lacked documentation of the diet change and lacked interventions to address Resident #111 ' s choking risk. Record contained a significant change FCS dated 3/23/17 that indicated resident required supervision with eating and walking and experienced impaired short-term memory, long-term memory, memory recall, and decision making ability. NSA/HCSP dated 3/23/17 documented the same nutrition service as in the 9/7/16 NSA/HCSP. The 3/23/17 NSA/HCSP now included "House supplement with one ounce of condensed milk added for extra calories. Resident's diet has changed from regular texture diet with thin liquids to mechanical ground soft diet with nectar thick liquids." On 3/30/17 at 8:30 a.m. a licensed nurse documented resident started choking on pancake. Gave Heimlich maneuver one time and resident was able to dislodge pancake. Medical care provider documented on 4/12/17 resident being seen today at the request of nursing staff for evaluation of dark purple bruising to chest and continues to choke easily on food. Assessment: 1. Dementia with behaviors--increased weakness, difficulty swallowing, poor intake, and confusion. 2. Bruising-skin is very thin and frail, resident is prone to bruising and injuries. 3. Dysphagia-continue soft foods and thickened liquids. A licensed nurse documented on 4/12/17 (unable	S3026		

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to read time documented) that resident was eating a brownie and started to choke. A physical therapy assistant performed the Heimlich maneuver until resident's airway (unable to read writing). Medical care provider changed diet order to mechanical texture with nectar thick liquids, resident not to eat bread.

The record contained a signed medical care provider order dated 4/12/17 for mechanical texture diet with ground meat, no bread, or bread-like foods. Nectar thick liquids.

The NSA/HCSP lacked documentation of the diet change and continued to lack interventions to address ongoing choking risk.

A licensed nurse documented on 4/24/17 at 6:00 p.m. that staff reported resident choked on a potato. Resident was able to cough it up.

Medical care provider documented on 4/26/17, resident being seen today at the request of nursing staff following choking episode. Staff report resident was observed coughing/choking after drinking thin liquids two days ago. Nursing staff also report resident has been observed picking food up off of other resident plates and eating it before staff can get to resident to stop resident. Assessment included order provided for nectar thick liquids, continue mechanical soft diet. [Note resident had order for nectar thick liquids starting 3/10/17.]

Licensed nurse C documented at 5:30 p.m. on 6/20/17 that resident was eating shredded pork when resident started choking. Heimlich maneuver was not indicated as resident was getting air. Resident was able to clear airway with a few back thumps by this nurse. Medical care

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S3026	Continued From page 6 provider ordered speech therapy to evaluate. Medical care provider documented on 6/21/17 resident being seen today at the request of nursing staff following choking episode when eating pork during dinner. Resident was eventually able to clear (his/her) throat. Dysphagia-Order provided for speech therapy to evaluate. The record contained a speech therapy evaluation dated 6/21/17 that documented skilled speech therapy bedside swallow evaluation in order to determine resident's level of functioning and aspiration risk. Resident has late stage dementia with behaviors and had recent choking incident on mechanical soft diet. Resident assessed to eat one bite of tator tot with overt signs and symptoms of aspiration/penetration during swallow. Resident had adequate coughing to clear airway. Speech therapist recommended diet downgrade to puree with nectar thick liquids. Staff to continue monitoring resident for aspiration of nectar thick liquids. Assist for feeding is recommended for increased oral intake. Licensed nurse documented on 6/21/17 (no time entry documented) new order per medical care provider to change diet to pureed food and stay on nectar thick liquids. Continue to monitor for choking with liquids and notify medical care provider. The NSA/HCSP lacked revision to include health care services to address resident's dysphagia and risk for choking and aspiration. On 8/28/17 surveyor observed the resident as follows:	S3026		

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S3026	Continued From page 7 12:00 p.m. Resident sat in chair at a table in activity room while other residents were in the dining room. 12:15 p.m. life enrichment coordinator asked resident to come eat. Resident remained seated in activity room. 12:21 p.m. three employees walked by shortly after each other with each employee looking in the room at resident. 12:25 p.m. an employee entered the room and told resident to come eat. Another employee came in with medication for resident. Medication aide stated resident pushed him/her away and would come eat when ready. 12:30 p.m. resident up pushing a chair around in activity room. 1:08 p.m. licensed nurse K went to resident in activity room and told resident "We need to go get you something to drink and eat. Come with me." Resident got up and walked with licensed nurse K to the dining room. 1:14 p.m. resident sitting in dining room. Licensed nurse C served resident a red thickened liquid in a glass and another employee served resident a divided plate with 2 different pureed food items. Surveyor observed that no employee sat by resident or monitored resident while he/she took 3 to 4 bites of food and spilled drink. Surveyor observed resident cough with each bite taken. 1:18 p.m. resident up from table and walked out of dining room.	S3026		

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S3026	Continued From page 8 On 8/30/17 surveyor observed resident as follows: 11:43 a.m. Employee walked resident to dining room and seated resident at a table. No food or drink on table. Resident began moving empty drinking glasses and silverware around on table. 11:45 a.m. resident up and walked into the drink preparation area. Another employee escorted resident out of dining room. Resident then started pushing an empty wheelchair into the dining room. An employee took the wheelchair and escorted resident out of dining room. 11:47 a.m. resident walked back into dining room and went to a table where another resident sat and took that resident's juice. An employee took the juice and escorted resident out of dining room to the activity room. 12:00 p.m. resident walking in hallway and an employee then escorted resident into dining room, seated resident at table, and gave resident thickened liquid to drink and tomato soup. Surveyor observed that an employee did not sit with resident or monitor resident while he/she drank the liquid and ate one-third of the tomato soup. Surveyor observed that resident quickly put food in mouth with no time between bites. 12:08 p.m. resident got up and walked out of dining room. 12:14 p.m. employee brought resident back to dining room and served pureed food. Resident quickly took 4 bites and got up and walked out of dining room into hallway. 12:21 p.m. Surveyor heard an employee say	S3026		

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"What has (resident) got?" Another employee stated resident had picked up a tator tot from another resident's plate and was eating the tator tot.

During an interview at 1:24 p.m. on 8/28/17, certified staff L stated a staff member sat with resident at meals because resident would play with food.

Interview with resident's hospice nurse M at 12:40 p.m. on 8/30/17 who stated resident was at risk for aspiration and this was determined by the two speech therapy evaluations.

Interview at 12:54 p.m. on 8/30/17, licensed nurse C stated a certified staff member was to sit with resident at meals due to resident's history of choking and risk for aspiration.

During an interview at 1:22 p.m. on 8/30/17, licensed nurse D stated "It doesn't technically have one." when asked for interventions in the negotiated service agreement/health care service plan to address resident's risk for aspiration.

At 3:10 p.m. on 8/30/17, dietary employee O when asked how shredded pork was prepared for and served to a resident on a mechanical texture diet with ground meat, stated shredded pork was cut up into small pieces.

During an interview at 3:14 p.m. on 8/30/17, dietary manager N stated shredded pork was to be ground up with sauce for a mechanical texture diet with ground meat. Dietary manager N provided the written menu instructions for the meal served 6/20/17 that documented shredded pork to be ground up with gravy.

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S3026	Continued From page 10 During an interview at 3:16 p.m. on 8/30/17, licensed nurse C confirmed he/she was the nurse who performed "back thumps" on resident the evening of 6/20/17 when resident choked on shredded pork. Licensed nurse C stated the pork was cut up in small pieces. Licensed nurse C confirmed the pork had not been mechanically ground prior to serving to resident. The operator failed to ensure resident #111 was not subjected to neglect when licensed nurses failed to provide and coordinate services to address resident's choking risk, when staff neglected to serve pork ground per diet order and resident choked, and when staff failed to monitor resident's behavior to ensure he/she did not take thin liquids or foods that posed a choking risk from other residents The immediate jeopardy for resident #111 was removed when operator B and licensed nurse C provided a written plan at 5:40 p.m. on 8/30/17 that documented: " We will have a printed copy of each resident's diet in the Daily Resident Meal Check Binder that is located in the galley. A certified staff member will sit at each table in the assisted dining room to monitor residents for any swallowing or choking issues and will report to the nurse on the floor, so that the nurse can monitor resident eating and drinking. We will have staff education at each shift on signs/symptoms of aspiration such as coughing, difficulty breathing, clearing throat, vomiting/regurgitation, drooling, impaired voice, "silent aspiration" such as chest discomfort, wheezing, recurring vomiting, noisy breathing or	S3026		

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even latent coughing, starting this evening and running through each shift until Friday and call in all PRN (as needed)/part time staff to attend one of the scheduled mandatory training meetings August 30-September 1, 2017. Those staff who have not completed the required education will be taken off the schedule until training is complete.

We will review signs and symptoms of aspiration during the mandatory all staff meeting on September 14th and yearly thereafter. All new staff will be initially trained during orientation beginning with all new hires on 8/31/17.

(Resident #111's) Personal Service Agreement will be updated to reflect (resident's) diet interventions, risk of aspirations, and fall risk with interventions. This will be completed by August 31, 2017. "

- Record review for resident #112 revealed an admission date of 7/6/12 and diagnoses of Alzheimer's disease, rheumatoid arthritis, and history of stroke.

Functional capacity screen(FCS) dated 3/7/16 indicated resident was independent with eating

Negotiated service agreement/health care service plan (NSA/HCSP) dated 3/7/17 documented "Resident has been changed to a mechanical ground meats with nectar thick liquids to prevent aspiration. Provide texture modified foods. Provide thickened liquids: nectar consistency. Be alert to coughing or choking while eating."

Resident log notes contained the following entries by licensed nurses:

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11/24/16 (no time entry documented) new order per medical care provider to change diet to mechanical soft with nectar thick liquids.

3/9/17 at 12:00 p.m. licensed nurse C documented resident had a choking incident during lunch, medical care provider notified, and speech therapy evaluation ordered.

3/10/17 at 2:00 p.m. licensed nurse D documented order received for resident to be changed to pureed diet and continue nectar thick liquids.
FCS dated 3/22/17 indicated resident independent with eating; was unable to perform bathing, dressing, toileting, transferring, and mobility; was incontinent of urine; experienced impaired short-term memory, long-term memory, memory recall, and decision making ability; and required a mechanical lift for transferring and a wheelchair for mobility.

The NSA/HCSP dated 3/22/17 documented "Resident's diet has changed to pureed diet with nectar thick liquids for aspiration precautions. Provide texture modified foods. Provide thickened liquids: nectar consistency. Be alert to coughing or choking while eating." The NSA/HCSP also documented toileting assistance of two staff members to transfer resident to toilet using a mechanical lift. Resident alerts staff when needs to toilet. Resident to be toileted before and after meals and as needed. Resident requires assistance related to the inability to stand independently during bathroom tasks.

At 12:20 p.m. on 8/29/17, along with operator B, surveyor observed resident #112 eating lunch

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with other residents in the Country Kitchen (an area separate and not visible from the east and west dining rooms). Operator B stated that these residents liked to visit during meals so were allowed to eat in this area. Surveyor observed a staff member was not present in the Country Kitchen to observe and monitor resident #112 for coughing or choking while eating.

During an interview at 3:12 p.m. on 8/29/17, licensed nurse D stated an employee was not assigned to the Country Kitchen dining room to monitor resident #112 when eating. Licensed nurse C confirmed resident #112 required monitoring during meals due to risk for choking and/or aspiration.

Operator B failed to ensure resident #112 was not subjected to neglect when staff failed to monitor resident for choking and/or aspiration when eating.

During an interview at 1:30 p.m. on 8/29/17, certified staff P stated resident required staff to assist with toileting every 30 minutes to 2 hours when resident requested to be toileted.

At 1:40 p.m. on 8/29/17, certified staff Q informed certified staff P that resident #112 requested to go to the bathroom.

At 1:44 p.m. on 8/29/17 observed certified staff Q mobilize resident in wheelchair to the resident's room. Resident repeatedly stated he/she needed to go to the bathroom. Certified staff Q reassured resident he/she would be toileted. Certified staff P, certified staff R, and certified staff G entered the resident's room. Certified staff R placed a sling (for use with the mechanical lift) on the

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S3026	Continued From page 14 resident's bed and then placed a gait belt around the resident's waist. Certified staff R and certified staff G then transferred resident from wheelchair to bed while resident stated he/she wanted to go into bathroom. Surveyor observed that resident did bear weight during transfer. With resident lying on back on the bed, certified staff Q told resident "go ahead and go." Resident became upset and stated he/she did not want to go (urinate) in clothes. Certified staff Q pulled resident's clothing down to ankles and told resident that he/she had a brief on and could go to bathroom in the brief. Certified staff R stated staff members could not safely place resident on toilet. During an interview at 3:20 p.m. on 8/29/17 licensed nurse D stated certified staff members were to toilet resident on a bedpan. Licensed nurse C stated resident wore an incontinence brief but certified staff members were probably transferring resident to the toilet with the mechanical lift. Licensed nurse C stated resident was not to put weight on legs due to condition of his/her knees. Licensed nurse C stated he/she knew resident wanted to be placed on toilet and did not like to be placed on bedpan. Operator failed to ensure no resident was subjected to abuse when resident #112 requested to be placed on toilet and was told by staff member to urinate in brief.	S3026		
S3105 SS=D	26-41-202 (j) Negotiated Service Agreement Outside Resource (j) If a resident's negotiated service agreement includes the use of outside resources, the designated facility staff shall perform the	S3105		

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S3105	Continued From page 15 following: (1) Provide the resident, 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, with a list of providers available to provide needed services; (2) assist the resident, if requested, in contacting outside resources for services; and (3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice This REQUIREMENT is not met as evidenced by: KAR 26-41-202(j)(3) The facility reported a census of 37 residents. The sample included 3 residents and 3 residents focus reviewed. Based on record review, observation, and interview for 1 (#112) of 3 residents sampled, the licensed nurse failed to monitor the services provided by an outside resource. Findings included: - Record review for resident #112 revealed an admission date of 7/6/12 and diagnoses of Alzheimer's disease, rheumatoid arthritis, and history of stroke. Functional capacity screen dated 3/22/17 indicated resident was unable to perform bathing, dressing, toileting, transferring, and mobility; was incontinent of urine; experienced impaired short-term memory, long-term memory, memory recall, and decision making ability; and required a mechanical lift for transferring and a wheelchair	S3105		

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S3105	Continued From page 16 for mobility. Negotiated service agreement/health care service plan documented a home health nurse provided wound care for the resident's pressure ulcer. The resident log notes contained an entry by licensed nurse D at 11:00 a.m. on 8/10/17 that resident complained of pain to buttocks. Licensed nurse D documented "Upon assessment this nurse noticed a scant area in gluteal cleft that was open." Medical care provider ordered skilled nursing for wound management and monitoring. Resident already on home health and licensed nurse D notified home health of visit order. The resident's record lacked documentation of skilled nursing visits for wound care and assessments of wound's response to treatment. At 1:52 p.m. on 8/29/17, observed resident positioned on left side in bed while certified staff Q and certified staff P provided incontinence care. Surveyor observed a dressing covering an area on left inner buttock. During an interview at 4:58 p.m. on 8/29/17, licensed nurse C stated he/she monitored services provided by an outside resource by observing the resident's wound while the home health nurse provided wound care. Licensed nurse C confirmed he/she had not observed resident's wound and the wound's response to treatment. The licensed nurse failed to monitor the services provided to resident #112 by an outside resource.	S3105		

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S3170	Continued From page 17	S3170		
S3170 SS=D	26-41-204 (g) (h) Health Care Services (g) Skilled nursing care shall be provided in accordance with K.S.A. 39-923 and amendments thereto. (1) The health care service plan shall include the skilled nursing care to be provided and the name of the licensed nurse or agency responsible for providing each service. (2) The licensed nurse providing the skilled nursing care shall document the service and the outcome of the service in the resident ' s record. (3) A medical care provider ' s order for skilled nursing care shall be documented in the resident ' s record in the facility. A copy of the medical care provider ' s order from a home health agency or hospice may be used. Medical care provider orders in the clinical records of a home health agency located in the same building as the facility may also be used if the clinical records are available to licensed nurses and direct care staff of the facility. (4) The administrator or operator shall ensure that a licensed nurse is available to meet each resident ' s unscheduled needs related to skilled nursing services. (h) A licensed nurse may provide wellness and health monitoring as specified in the resident ' s negotiated service agreement. (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice This REQUIREMENT is not met as evidenced by:	S3170		

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S3170	Continued From page 18 KAR 26-41-204(g)(2) The facility reported a census of 37 residents. The sample included 3 residents and 3 residents focus reviewed. Based on record review, observation, and interview for 1 (#112) of 3 residents sampled, the operator failed to ensure the licensed nurse providing skilled nursing care documented the service and the outcome of the service in the resident's record. Findings included: - Record review for resident #112 revealed an admission date of 7/6/12 and diagnoses of Alzheimer ' s disease, rheumatoid arthritis, and history of stroke. Functional capacity screen dated 3/22/17 indicated resident was unable to perform bathing, dressing, toileting, transferring, and mobility; was incontinent of urine; experienced impaired short-term memory, long-term memory, memory recall, and decision making ability; and required a mechanical lift for transferring and a wheelchair for mobility. Negotiated service agreement/health care service plan dated 3/22/17 documented a home health nurse provided wound care for the resident's pressure ulcer. The resident log notes contained an entry by licensed nurse D at 11:00 a.m. on 8/10/17 that resident complained of pain to buttocks. Licensed nurse D documented "Upon assessment this nurse noticed a scant area in gluteal cleft that was open." Medical care provider ordered skilled nursing for wound management and monitoring. Resident already	S3170		

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S3170	Continued From page 19 on home health and licensed nurse D notified home health of visit order. The resident's record lacked documentation of skilled nursing visits for wound care and assessments of wounds response to treatment. At 1:52 p.m. on 8/29/17, observed resident positioned on left side in bed while certified staff Q and certified staff P provided incontinence care. Surveyor observed a dressing covering an area on left inner buttock. At 4:58 p.m. on 8/29/17, licensed nurse C confirmed the resident's record lacked documentation of skilled nursing care provided. The operator failed to ensure the licensed nurse providing skilled nursing care to resident #112 documented the service and the outcome of the service in the resident's record.	S3170		
S3201 SS=D	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of	S3201		

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S3201	Continued From page 20	S3201		

medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-205(d)(3)(C)

The facility reported a census of 37 residents. The sample included 3 residents and 3 residents focus reviewed. Based on record review, observation, and interview for 1 (#112) of 3 residents sampled, the operator failed to ensure the licensed nurse or medication aide remained with the resident until medications were applied.

Findings included:

- Record review for resident #112 revealed an admission date of 7/6/12 and diagnoses of Alzheimer's disease, history of stroke, and rheumatoid arthritis.

Functional capacity screen dated 3/22/17 indicated resident was unable to perform management of medications and treatments. Negotiated service agreement/health care service plan dated 3/22/17 documented facility staff provided assistance with administration of medications.

At 1:52 p.m. on 8/29/17, observed resident receiving incontinence care in resident's room. Observed a clear plastic medication cup that contained powdery substance and a plastic tube sitting on the dresser in the resident's room. Surveyor observed that certified staff did not bring these 2 items into the resident's room and did not

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S3201	Continued From page 21 apply these to the resident. At 3:04 p.m. on 8/29/17, accompanied by licensed nurse C, returned to resident's room. Licensed nurse C picked up the medication cup from the resident's dresser and stated this was Nystatin (topical anti-fungal powder) and the tube of Risamine (menthol and zinc oxide ointment to prevent and heal skin irritation caused by urinary and fecal incontinence). Licensed nurse C confirmed the person administering these topical medications did not remain with the resident until applied to the resident. The operator failed to ensure the licensed nurse or medication aide remained with resident #112 until medications were applied.	S3201		
S3248 SS=E	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual	S3248		

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S3248	Continued From page 22 does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-103(d)(1)(3) The facility reported a census of 37 residents. The sample included 3 residents and 3 residents focus reviewed. Based on record review and interview for 1 of 1 licensed nurse file reviewed, the business office manager failed to ensure the employee's file contained evidence of licensure at the time of employment and for 1 of 4 certified employee files reviewed the business office manager failed to ensure the file contained supporting documentation at the time of employment from the Kansas nurse aide registry that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home. Findings included: - Review of employee files at 2:09 p.m. on 8/29/17 with business office manager E revealed the following: Licensed nurse B hired 5/3/17 with proof of licensure with the Kansas state board of nursing dated 6/26/17. Certified staff G hired 5/10/17 with documentation	S3248		

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S3248	Continued From page 23 from the Kansas nurse aide registry dated 8/24/17 that the employee did not have a finding of having abused, neglected, or exploited a resident in an adult care home. Business office manager E confirmed he/she did not request the required documentation when these employees were hired. At the time of employment for each employee, the business office manager failed to ensure the licensed nurse's file contained evidence of licensure and the certified staff file contained supporting documentation from the Kansas nurse aide registry that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home.	S3248		
S3310 SS=E	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	S3310		

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S3310	Continued From page 24 by: KAR 26-41-207(c) The facility reported a census of 37 residents. The sample included 3 residents and 3 residents focus reviewed. Based on record review and interview for 2 (#111 and #112) of 3 residents sampled and 2 of 5 employee files reviewed, the operator failed to ensure the facility'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: - Record review for resident #111 revealed an admission date of 5/8/12 and diagnoses of progressive cognitive decline and dysphagia. Record contained a TB symptom screen dated 8/18/16. Record lacked a subsequent TB symptom screen dated on or before 8/18/17. At 1:37 p.m. on 8/28/17, licensed nurse C confirmed the resident's record lacked an annual TB symptom screen. For resident #111, the operator failed to ensure the facility's compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. - Record review for resident #112 revealed an admission date of 7/6/12 and diagnoses of Alzheimer's disease, rheumatoid arthritis, and history of stroke. Record contained a TB symptom screen dated 8/18/16. Record lacked a subsequent TB symptom screen dated on or before 8/18/17.	S3310		

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S3310	Continued From page 25 At 11:33 a.m. on 8/29/17, licensed nurse C confirmed the resident's record lacked an annual TB symptom screen. For resident #112, the operator failed to ensure the facility's compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. - Review of employee files at 2:09 p.m. on 8/29/17 revealed the following: Certified staff H hired 7/5/17 with documentation of a TB skin test on 7/27/17. This TB skin test was not completed within 7 days of employment and the file lacked documentation of a second TB skin test within 21 days of the first TB skin test. Certified staff J hired 8/1/17 with no documentation of TB testing. At 2:26 p.m. on 8/29/17, licensed nurse D stated he/she did not perform a second TB skin test for certified staff H and had not performed any TB testing for certified staff J. The operator failed to ensure the facility's compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		