STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087083	A. BUILDING: _____ B. WING _____	02/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNDER'S CREST, LLC	6887 E ROCKHILL STREET WICHITA, KS 67206

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named facility on 1-19-17, 1-30-17, 1-31-17, 2-2-17, 2-6-17, 2-7-17, and 2-8-17. Revised 2567 sent to facility on 2-14-17.	S 000		
S 135 SS=D	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment. This STANDARD is not met as evidenced by: KAR 26-41-103(h)(C) The facility identified a census of 22 residents. The sample included 3 residents and 4 focus	S 135		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 135	Continued From page 1	S 135		

review residents. Based on record review and interview for 1(#200) of 3 residents sample, the operator/licensed nurse failed to ensure designated staff informed the resident's legal representative or designated family member upon occurrence of an accident involving the resident that results in injury and has the potential for requiring a physician's intervention or a need to alter treatment significantly.

Findings included:

- Record review for resident #200 revealed an admit date of 10-16-15 with diagnoses of dementia, chronic obstructive pulmonary disease, and congestive heart failure.

The functional capacity screen dated 10-13-16 recorded resident required physical assistance with bathing, dressing, toileting, transfer, unable to assist with walking/mobility, management of medications or treatments, experienced impaired short term memory recall, long term memory, decision making. Current or recent problems included impaired decision making and falls/unsteadiness.

The negotiated service agreement dated 10-13-16 recorded resident bathed two times a week, toileted regularly, assist with dressing, grooming, medication management.

The health care service plan (HCS) dated 10-13-16 recorded resident required moderate assistance with all activities of daily living, moderate assist with toileting, changing briefs, dressing, physical assist of two for transfers and one to propel in wheelchair, may crush medications and put in applesauce/pudding/jelly

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S 135	Continued From page 2	S 135		

as resident pocket pills and will spit out. Resident oriented to person. Therapy or Treatments: "lab test, accu-checks, wound care, antibiotics, etc."

The nurses notes recorded the following:
On 1-9-17 at 11:23 a.m. recorded, "fall and follow up. It was reported to this nurse at approximately 10:30 p.m. last night that resident had called out for help - upon entering resident's room, resident was observed lying on fall mat, wrapped in blanket on right side, when asked resident if was OK (he/she) stated yes but (his/her) head hurt - resident presented with a hematoma on the right forehead - denied pain elsewhere - adequate range of motion for this resident . . Caregivers stated that when they put resident to bed at approximately 10:15 p.m., resident was very resistive and agitated. . . .Will continue to have caregivers observed and report signs/symptoms of pain or discomfort to nurse. " Signed operator/licensed nurse A.

The record lacked documentation the legal representative was notified of the fall with head injury.

Written statement of operator/licensed nurse A received 2-1-2017 at 10:30 a.m. stated " I observed a hematoma about the size of a ping pong ball with a small abrasion. "

During tour of commons area on 1-19-17 at 1:45 p.m. observed resident #200 sitting in a recliner facing the television in front of the medication room. Observed large raised hematoma approximately 5 centimeters (CM) by 5 CM on right side of resident #200 ' s forehead with purple/green/yellow bruising down face and neck.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 135	Continued From page 3	S 135		

The hematoma was black in color with approximately 1 CM blood blister in center. When asked what happened to his/her head , resident #200 stated he/she fell and hit head. When asked if it hurt as he/she stated it did not hurt as bad today as it did when he/she fell and hit head.

Interview on 1-19-17 at 2:25 p.m. with family friend stated was upset when first observed (resident) with the head injury. He/she took a picture and sent it to the resident ' s family member on 1-16-17 because they were not notified of fall. Family friend stated he/she comes to facility daily to check on resident for family.

Nurses notes documented:
1-26-17 at 9:27 a.m. Resident has an area on the left side of his/her head that has opened and has yellow drainage. This nurse contacted medical care provider and received order for wound culture and to start Bactrim DS two times a day (antibiotic) for seven days. Order faxed to laboratory. Signed Operator/licensed nurse A.

Record lacked documentation the legal representative was notified of the wound.

The nurses notes lacked further documentation and lacked documentation of the date the culture obtained from wound on back left side of head.

The verbal order dated 1-26-17 recorded: Culture open area on left side of head. Bactrim DS two times a day for seven days. Signed by licensed nurse A as written on 1-26-17.

Interview on 1-30-17 at 3:25 p.m. with licensed nurse B stated he/she obtained the culture and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 135	Continued From page 4	S 135		

sent to lab on 1-26-17 and was aware of order for Bactrim DS (antibiotic) two times a day for seven days to be started.

The record lacked documentation the legal representative was not notified of need for (antibiotic) Bactrim DS two times a day for seven days.

Review of the Medication Administration Record (MAR) provided on 1-30-17 at 1:30 p.m. lacked documentation that Bactrim DS (antibiotic) two times a day for seven days was administered for wound infection on left side of head.

Interview on 1-30-17 at 3:25 p.m. with licensed nurse B stated and confirmed the order for Bactrim DS (antibiotic) two times a day for seven days and further stated he/she was not aware it was not given. During interview, licensed nurse B stated she was not aware of the lab results and looked for lab culture results. The results received via fax 1-30-17 at 8:35 a.m. read: Large amount of Staphylococcus aureus - methicillin resistant. Licensed nurse B stated the legal representative was not notified of lab results that indicated resident had large amount of staphylococcus aureus.

At approximately 3:30 p.m. on 1-30-17, license nurse B reported he/she contacted the pharmacy and the medication had not been delivered due to a hold for payment. Confirmed he/she had not contacted the physician or family regarding medication not being administered.

Telephone interview on 2-2-17 at 12:30 p.m. with legal representative state he/she was not notified when resident had fall with injury to head until his/her family care giver observed the injury to

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	N087083	A. BUILDING: _____ B. WING _____	02/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 135	Continued From page 5 head and sent a photo of the injury to him/her. The legal representative was not aware (resident) had a draining wound on left side of head, needed antibiotics, and culture of wound identified large amount of staphylococcus aureus-methicillin resistant. The legal representative was upset as (resident) was very ill with MRSA prior to admission to facility. The legal representative stated he/she was not notified of any condition changes recently and the staff have his/her phone number or can inform the caregiver sent in daily by the family as he/she can always get a hold of him/her. For resident #200, the operator/licensed nurse failed to ensure designated staff informed the resident's legal representative or designated family member upon occurrence of an accident involving the resident that results in injury and has the potential for requiring a physician's intervention or a need to alter treatment significantly.	S 135		
S3026 SS=L	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. This REQUIREMENT is not met as evidenced by:	S3026		

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S3026	Continued From page 6 KAR 26-41-101(f)(1)(B) The facility identified a census of 22 residents. The sample included 3 residents and 4 focus reviewed residents. For 1 (#200) of 3 residents sampled, the operator/licensed nurse failed to ensure resident #200 was not subjected to neglect when licensed nurse failed to implement orders for treatment of draining wound. The operator/licensed nurse failed to ensure antibiotics for draining wound administered to resident when ordered and failed to provide direction to certified staff to prevent the spread of infection when the draining wound that was identified to have, "Large amount Staphylococcus Aureus - Methicillin Resistant " (MRSA). The operator/licensed nurse further failed to implement interventions to address the resident ' s risk for falls identified at admission. The resident experienced an unwitnessed fall with large protruding hematoma to right side of forehead above right eye. These failures placed the resident in immediate jeopardy. Findings included: - Record review for resident #200 revealed an admit date of 10-16-15 with diagnoses of dementia, chronic obstructive pulmonary disease, and congestive heart failure. The functional capacity screen dated 10-13-16 recorded resident required physical assistance with bathing, dressing, toileting, transfer, unable to assist with walking/mobility, management of medications or treatments, experienced impaired short term memory recall, long term memory, decision making. Current or recent problems included impaired decision making and	S3026		

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S3026	Continued From page 7 falls/unsteadiness. The negotiated service agreement dated 10-13-16 recorded resident bathed two times a week, toileted regularly, assist with dressing, grooming, medication management. The health care service plan (HCS) dated 10-13-16 recorded resident required moderate assistance with all activities of daily living, moderate assist with toileting, changing briefs, dressing, physical assist of two for transfers and one to propel in wheelchair, may crush medications and put in applesauce/pudding/jelly as resident pocket pills and will spit out. Resident oriented to person. Therapy or Treatments: "lab test, accu-checks, wound care, antibiotics, etc." The HCS lacked interventions to address resident #200 ' s risk for falls. The nurses notes recorded the following: On 1-9-17 at 11:23 a.m. recorded, "fall and follow up. It was reported to this nurse at approximately 10:30 p.m. last night that resident had called out for help - upon entering resident's room, resident was observed lying on fall mat, wrapped in blanket on right side, when asked resident if was OK (he/she) stated yes but (his/her) head hurt - resident presented with a hematoma on the right forehead - denied pain elsewhere - adequate range of motion for this resident . . Caregivers stated that when they put resident to bed at approximately 10:15 p.m., resident was very resistive and agitated. . . .Will continue to have caregivers observed and report signs/symptoms of pain or discomfort to nurse. " Signed operator/licensed nurse A.	S3026		

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S3026	Continued From page 8	S3026		

Written statement of operator/licensed nurse A received 2-1-2017 at 10:30 a.m. stated " I observed a hematoma about the size of a ping pong ball with a small abrasion. "

Written statement dated 1-8-17 from certified staff T recorded " certified staff W assisted him/her to put resident #200 to bed. Resident was combative and agitated. Floor pads down and told resident good night. About fifteen minutes later resident was yelling help, when I walked into room certified staff W and certified staff U was putting resident to bed and noted a lump on right side of resident ' s forehead. " Signed certified staff T.

Written statement dated 1-8-17 from certified staff W recorded " resident was combative, screaming he/she was cold at about 10:15 p.m. Resident put to bed and still combative. Resident refused to put oxygen on. . . Shortly after went to put another resident to bed, came out and heard another resident yelling help. Went and found resident #200 on floor on mat with covers wrapped around self and oxygen on floor. I got vital signs and put him/her back in bed and repositioned him/her. " Signed certified staff W.

During tour of commons area on 1-19-17 at 1:45 p.m. observed resident #200 sitting in a recliner facing the television in front of the medication room. Observed large raised hematoma approximately 5 centimeters (CM) by 5 CM on right side of resident #200 ' s forehead with purple/green/yellow bruising down face and neck. The hematoma was black in color with approximately 1 CM blood blister in center. When asked what happened to his/her head , resident #200 stated he/she fell and hit head. When asked if it hurt as he/she stated it did not

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	N087083	A. BUILDING: _____ B. WING _____	02/08/2017

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S3026	Continued From page 9	S3026		

hurt as bad today as it did when he/she fell and hit head.

Interview on 1-19-17 at 2:25 p.m. with family friend stated was upset when first observed (resident) with the head injury. He/she took a picture and sent it to the resident ' s family member on 1-16-17. Family friend stated he/she comes to facility daily to check on resident for family. The family friend then said the bruising it much larger now than it was and is darker in color with raised area on forehead.

On 1-30-17 at 2:50 p.m. observed a bed alarm on bed and a floor mat under bed for resident #200.

The HCS lacked description of use of bed alarm and floor mat or other interventions to address resident #200 ' s continued risk for falls and lacked description of service to address combative and agitated behavior.

Nurses notes documented:
1-26-17 at 9:27 a.m. Resident has an area on the left side of his/her head that has opened and has yellow drainage. This nurse contacted medical care provider and received order for wound culture and to start Bactrim DS two times a day (antibiotic) for seven days. Order faxed to laboratory. Signed Operator/licensed nurse A.

The nurses notes lacked further documentation and lacked documentation of the date the culture obtained from wound on back left side of head.

.The verbal order dated 1-26-17 recorded:
Culture open area on left side of head. Bactrim DS two times a day for seven days. Signed by licensed nurse A as written on 1-26-17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3026	Continued From page 10 Interview on 1-30-17 at 3:25 p.m. with licensed nurse B stated he/she obtained the culture and sent to lab on 1-26-17 and was aware of order for Bactrim DS (antibiotic) two times a day for seven days to be started. Review of the Medication Administration Record (MAR) provided on 1-30-17 at 1:30 p.m. lacked documentation that Bactrim DS (antibiotic) two times a day for seven days was administered for wound infection on left side of head. Interview on 1-30-17 at 3:25 p.m. with licensed nurse B stated and confirmed the order for Bactrim DS (antibiotic) two times a day for seven days and further stated he/she was not aware it was not given. During interview, licensed nurse B stated she was not aware of the lab results and looked for lab culture results. The results received via fax 1-30-17 at 8:35 a.m. read: Large amount of Staphylococcus aureus - methicillin resistant. At approximately 3:30 p.m. license nurse B reported he/she contacted the pharmacy and the medication had not been delivered due to a hold for payment. Confirmed he/she had not contacted the physician or family regarding medication not being administered. Interview on 1-30-17 at 2:45 p.m. with certified staff C and certified staff K stated they were not aware of any wound to left side of resident ' s head. Certified staff C and K both stated there were no infection control procedures in place that they are aware of. On 1-19-17 at 2:30 p.m. observed resident #200 lying back in recliner with head leaning back on head rest. The wound to back of left side/back of	S3026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3026	Continued From page 11	S3026		

head was not covered and observed crusted area in hair to side/back of head in contact with the recliner head rest.

On 1-31-17 at 10:35 a.m. observed resident #200 sitting in a different recliner. Interview with certified staff R stated resident had something on left side of head but not sure what and further stated he/she had no dressing on left side of head. Certified staff stated he/she did not clean the recliner prior to or after the resident sat in it.

On 1-31-17 at 10:05 a.m. asked licensed nurse B for a copy of infection control policy and procedure for MRSA.

On 1-31-17 at 10:20 a.m. received a copy of universal precaution guidelines from licensed nurse B who stated this was the policy and procedure provided. The Policy stated: ' Care staff should perform all tasks at the facility as if all blood and specified body fluids were infected with HIV, HBV, or other infectious diseases. '

The HCS lacked interventions to address care of resident #200 ' s draining wound and lacked interventions or instructions to prevent the spread of MRSA .

For resident #200, the operator/licensed nurse failed to ensure resident #200 was not subjected to neglect when licensed nurse failed to implement interventions to address the resident ' s risk for falls and the resident experienced a fall resulting in a large, protruding hematoma to the right side of the forehead. The operator/licensed nurse failed to ensure the licensed nurse implemented orders for treatment of draining wound that was later identified to contain MRSA. The operator/licensed nurse failed to ensure

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S3026	Continued From page 12 antibiotics for draining wound administered to resident when ordered and failed to ensure certified staff aware of the wound with purulent draining and implement necessary infection control procedures for MRSA. These failures placed residents in immediate jeopardy. The jeopardy was corrected on 2-1-17 when the facility provided a plan to: - ensure that all medications were placed on the electronic MAR when received - facility nurses to make a daily check of the electronic MAR to approve an pending pharmacy actions - ensure a full supply of medications are delivered as ordered and may enforce a 30 day discharge notice to the resident/legal representative for nonpayment or refusal to supply prescribed medications - any resident with a confirmed MRSA culture will be assigned a specific chair in the common area and in the dining room; no other resident will be placed in the chair and it will be disinfected every shift - all resident ' s laundry will remain separate from all other resident ' s laundry	S3026		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced	S3101		

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	N087083	A. BUILDING: _____ B. WING _____	02/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNDER'S CREST, LLC	6887 E ROCKHILL STREET WICHITA, KS 67206

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S3101	Continued From page 13 by: KAR 26-41-202(h) The facility identified a census of 22 residents. The sample included 3 residents and 4 focus review residents. Based on record review and interview for 2 (#100, 200) 3 residents sampled and 3 (#400, #401, #403) of 4 focus reviewed residents, the operator failed to ensure each individual involved in the development of the Negotiated Service Agreement (NSA) shall sign the agreement. Findings included: - Record review on 1-19-17 at 3:20 p.m. for resident #100 revealed an admit date of 1-12-17 with diagnoses of dementia without behaviors and arthritis. The functional capacity screen dated 1-11-17 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, eating, unable to assist with management of medications/treatments, experienced incontinence of bowel and bladder control, short term memory loss, memory recall, long term memory loss, impaired decision making and falls/unsteadiness. The current NSA and health care service plan dated 1-11-17 signed by operator/licensed nurse A documented interventions to address resident ' s needs and lacked the signature of resident or legal representative. - Record review on 1-30-17 at 12:05 p.m. for resident #200 revealed admit date of 10-16-15 with diagnoses of dementia, chronic obstructive pulmonary disease, hypothyroidism, anxiety, and	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087083	A. BUILDING: _____ B. WING _____	02/08/2017

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S3101	Continued From page 14 congestive heart failure. The functional capacity screen dated 10-13-16 recorded resident required supervision with eating, physical assistance with bathing, dressing, toileting, transfer, unable to manage medications/treatments, unable to walk or assist with mobility, experienced incontinence of bowel and bladder control, short term memory, memory recall, long term memory, impaired decision making, inappropriate behaviors and experienced falls/unsteadiness. The current NSA and health care service plan dated 10-13-16 signed by operator/licensed nurse A documented interventions to address resident ' s needs and lacked the signature of resident or legal representative. - Record review on 1-31-17 at 12:30 p.m. for resident #400 revealed and admit date of 1-11-16 with diagnoses of dementia and depression. The functional capacity screen dated 1-11-16 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, eating, unable to assist with management of medications/treatments, experienced short term memory loss, memory recall, long term memory, decision making, impaired decision making, able to express requests for basic needs but has limited ability, and experienced falls/unsteadiness. The current NSA and health care service plan dated 1-11-16 signed by operator/licensed nurse A and licensed nurse B documented interventions to address resident ' s needs and lacked the signature of resident or legal representative.	S3101		

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S3101	Continued From page 15 - Record review on 1-31-17 at 1:05 p.m. for resident #401 revealed an admit date of 1-11-17 with diagnoses of dementia and non-insulin dependent diabetic. The functional capacity screen dated 1-11-17 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, eating, unable to assist with management of medications/treatments, communication required prompting, experienced incontinence of bowel and bladder control, short term memory loss, memory recall, long term memory, impaired decision making, and falls/unsteadiness. The current NSA and health care service plan dated 1-11-17 by operator/licensed nurse A and licensed nurse B documented interventions to address resident ' s needs and lacked the signature of resident or legal representative. - Record review on 1-31-17 at 3:40 p.m. for resident #403 revealed an admit date of 4-22-16 with diagnoses of dementia, paranoid schizophrenia, and bipolar disorder. The functional capacity screen dated 4-22-16 recorded resident required physical assistance with eating and transfer, unable to assist with bathing, dressing toileting, walking/mobility, management of medications/treatments, able to express request for basic needs but has limited ability, frequent difficulties integrating information, experienced short term memory loss, memory recall, long term memory, decision making, impaired decision making, socially inappropriate and disruptive behaviors, and falls/unsteadiness. The current NSA and health care service plan	S3101		

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S3101	Continued From page 16 dated 4-22-16 by operator/licensed nurse A and licensed nurse B documented interventions to address resident ' s needs and lacked the signature of resident or legal representative. Interview on 1-31-17 at 4:45 p.m. with operator/licensed nurse A and licensed nurse B stated and confirmed the NSA's were not signed by resident or legal representative. For residents #100, #200, #400, #401, and #403, the operator failed to ensure each individual involved in the development of the NSA shall sign the agreement.	S3101		
S3102 SS=D	26-41-202 (i) Negotiated Service Agreement Service Received (i) Each administrator or operator shall ensure that each resident receives services according to the provisions of that resident ' s negotiated service agreement This REQUIREMENT is not met as evidenced by: KAR -41-202(i) The facility identified a census of 22 residents. The sample included 3 residents and 4 focus review residents. Based on 1 (#403) of 4 focus reviewed residents, the operator failed to ensure resident received services according to the provisions of the Negotiated Service Agreement (NSA). Findings included: - Record review for resident #403 on 1-31-17 at 3:40 p.m. revealed an admit date of 4-22-16 with	S3102		

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S3102	Continued From page 17	S3102		

diagnoses of dementia, paranoid schizophrenia, and bi-polar disorder.

The functional capacity screen dated 4-22-16 recorded resident required physical assistance with eating, transfer, unable to assist with bathing, dressing, toileting, walking/mobility, management of medications/treatments, incontinent of bowel and bladder control, able to express requests for basic needs but has limited ability, experienced short term memory loss, memory recall, long term memory, decision making, impaired decision making, and falls/unsteadiness.

The NSA dated 4-22-16 recorded resident received three meals a day, bath two times a week physical assist with toileting, dressing, grooming, facility staff to administer medications/treatments, skin assessments will be done weekly, hospice to provide skilled nursing, and hospice aide will provide a bath two times a week.

The health care service plan dated 4-22-16 recorded hospice will provide two baths a week. Facility staff is available to assist as needed. Resident incontinent daily. Resident needs assistance with all activities of daily living. Resident is a one to two person transfer depending on agitation level. Wheelchair for mobility. Can propel with fee and hands. Resident has a bed alarm, a hi-low bed to be kept in lowest position while in bed, a bolster mattress, fall mat and body alarm in place while in bed.

On 1-31-17 at 10:30 a.m. observed resident #403 on floor next to bed face down on floor mat. Bed alarm in bed not sounding. Notified certified staff F that resident was on floor face down. Certified staff and Advance Practioner Registered Nurse

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S3102	Continued From page 18 (APRN) came to resident room. The APRN assessed resident and with assistance of certified staff F and licensed nurse B, placed resident back in bed. Licensed nurse B stated and confirmed the bed alarm pad did not sound and he/she checked it and it was not working. Licensed nurse B stated that night shift staff is to check all pad/chair alarms to make sure they are working and no one stated the pad alarm was not working. For resident #403, the operator failed to ensure resident received services according to the provisions of the NSA staff failed to ensure the bed alarm was working.	S3102		
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 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.	S3200		

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S3200	Continued From page 19 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility identified a census of 22 residents. The sample included 3 residents and 4 focus review residents. Based on record review, observation, and interview for 1 (#200) of 3 residents sampled, the operator/licensed nurse failed to ensure all medications administered to resident in accordance with a medical care provider's written order, professional standards of practice, and each manufacturer's recommendations. Findings included: - Record review for resident #200 revealed an admit date of 10-16-15 with diagnoses of dementia, chronic obstructive pulmonary disease, hypothyroidism, anxiety, and congestive heart failure. The functional capacity screen dated 10-13-16 recorded resident unable to assist with medication administration. The negotiated service agreement dated 10-13-16 recorded facility staff will administer and document all prescription and over-the-counter medications as ordered by a physician or primary care practitioner. The Health Care Services (HCS) dated 10-13-16 recorded may crush medication and put in apple sauce/pudding/or jelly. Resident will pocket pills and spit them out. The verbal order dated 1-10-17 recorded mucinex 1200 Milligrams (MG) two times a day	S3200		

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	N087083	A. BUILDING: _____ B. WING _____	02/08/2017

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S3200	Continued From page 20	S3200		

for five days and then as needed for congestion.

The Medication Administration Record (MAR) dated 1-1-17 thru 1-30-17 recorded resident #200 received mucinex 1200 MG at 5:00 p.m. on 1-11-17, 1200 MG at 8:00 a.m. and 5:00 p.m. on 1-12-17, 1-13-17, and 1-14-17.

Resident #200 failed to get mucinex 1200 MG two times a day for 5 days as ordered by medical care provider.

The verbal order dated 1-26-17 recorded bactrim DS (antibiotic for infection) two times a day for seven days.

The MAR dated 1-1-17 thru 1-30-17 lacked documentation of bactrim DS being administered as of 1-30-17.

Nurses notes dated 1-26-17 at 9:27 a.m. recorded resident has an area on the left side of head that has opened and has yellow drainage. Medical care provider notified. Order for wound culture of drainage and bactrim DS two times a day for seven days received and faxed.

Interview on 1-30-17 at 3:25 p.m. with licensed nurse B stated and confirmed the antibiotic bactrim DS two times a day had not been received at facility yet and just found out it was a billing issue. The wound culture received today identified the wound had large amount of methicillin resistant staphylococcus aureus.

Resident #200 failed to receive bactrim DS antibiotic two times a day for seven days when ordered by medical care provider.

For resident #200, the operator/licensed nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3200	Continued From page 21 failed to ensure all medications administered to resident in accordance with a medical care provider's written order, professional standards of practice, and each manufacturer's recommendations.	S3200		
S3215 SS=D	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 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	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3215	Continued From page 22 expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h) The facility identified a census of 22 residents. The sample included 3 residents and 4 focus review residents. Based on 1 (#100) of 3 residents sampled, the operator/licensed nurse and certified medication aides failed to ensure all medications securely and properly stored in accordance with each manufacturer's recommendations or those of the pharmacy provider and with federal and state laws and regulations. Findings included: - Record review for resident #100 revealed an admit date of 1-12-17 with diagnoses of dementia without behavioral disturbance and arthritis. The functional capacity screen dated 1-11-17 recorded resident unable to manage medication administration. The negotiated service agreement dated 1-11-17 recorded the facility staff will administer and document all prescription and over-the-counter medications as ordered by a physician or primary care practitioner. The health care servic plan dated 1-11-17 recorded the resident generally takes medications whole but may crush if needed unless contraindicated.	S3215		

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S3215	Continued From page 23 Tour of medication room on 1-19-17 at 2:15 p.m. with licensed nurse B revealed an open bottle of liquid lorazepam (narcotic/anti-anxiety) two milligrams (MG) per milliliter (ML) in the refrigerator on top of second lock box. The label identified it belonged to resident #100. Licensed nurse B stated resident expired this morning and staff did not lock it up. On 1-19-17 at 2:20 p.m., licensed nurse B stated and confirmed lorazepam (narcotic/anti-anxiety) not secured properly. For resident #100, the operator/licensed nurse and certified medication aides failed to ensure all medications securely and properly stored in accordance with each manufacturer's recommendations or those of the pharmacy provider and with federal and state laws and regulations.	S3215		
S3245 SS=F	26-41-102 (a) Staff Qualifications Sufficent Staff (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident ' s functional capacity screening, health care service plan, and negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(a) The facility identified a census of 22 residents.	S3245		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3245	Continued From page 24	S3245		

The sample included 3 residents and 4 focus review residents. Based on interview, and record review for all residents, the operator/licensed nurse failed to ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with each resident ' s Functional Capacity Screening (FCS), Health Care Service Plan (HCSP) and Negotiated Service Agreement (NSA).

Findings included:

- Confidential interview stated he/she observed " residents placed in wheelchairs behind dining room tables in order to keep them from exiting the small dining room. Residents were begging to go to their rooms and being told they all had to stay in the dining room because there wasn't enough staff to be two places at once. One resident's entire face was bruised and I can only assume that it was from a fall. Grooming was horrible. All the residents I observed appeared to be in poor physical health as well as seriously demented. "

On 1-31-17 at 10:05 a.m. requested from licensed nurse B a copy of staffing schedules and payroll time sheets for all staff that worked at this facility from 1-7-17 through 1-14-17.

On 1-31-17 at 3:00 p.m. received staffing schedules and payroll time sheets from licensed nurse B. Licensed nurse B described the following staffing pattern prior to 1-11-17:
7:00 a.m. to 3:00 p.m. -- 5 certified staff plus a certified medication aide (CMA)
3:00 p.m. to 11:00 p.m. -- 5 certified staff plus a CMA
11:00 p.m. to 7:00 a.m. -- 4 certified staff plus 1

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S3245	Continued From page 25 CMA. Licensed staff further described the following staffing pattern starting on 1-11-17 : 7:00 a.m. to 3:00 p.m. -- 6 certified staff and 1 CMA 3:00 p.m. to 11:00 p.m. -- 6 certified staff plus 1 CMA 11:00 p.m. to 7:00 a.m. -- 4 certified staff plus 1 CMA Staffing schedule provided included schedules for 8 facilities operated by company. Review of schedule for 1-8-17 through 1-14-17 revealed only 1 " CMA " listed on schedule from 7 a.m. to 7 p.m. and 1 "CMA" listed on schedule from 7p.m. to 7 a.m. for all 8 facilities. 7:00 a.m. -3:00 p.m. listed 6 positions (not including CMA) for this facility; only 1-13-17 and 1-14-17 reflected 6 staff scheduled; other days showed 5 staff 3:00 p.m. - 11:00 p.m. listed 6 positions; only 1-14-17 reflected 6 staff scheduled; other days showed 5staff scheduled with 2 days showing fifth staff scheduled only part of the shift. 11:00 p.m. - 7:00 a.m. listed 4 positions and reflected 4 staff scheduled all dates Review of the time detail report for staff allocated to the facility (not including CMA) did not match the staffing schedule. The time detail report documented the following number staff allocated to the facility: 7:00 a.m. - 3:00 p.m. identified only 3 staff on 1-9-17, 4 staff for 1-10-17, and 2 staff for 6 hours of 1-14-17 day shift (3 staff for 2 hours)	S3245		

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S3245	Continued From page 26 3:00 p.m. - 11:00 p.m. identified 3 staff on 1-9-17, 4 staff on 1-10-17, 1-11-17; portions of shifts on 1-12-17, 1-13-17, and 1-14-17 with 2 or 3 staff. 11:00 p.m. - 7:00 a.m. identified only 2 staff on 1-12-17 and 1 staff on 1-14-17. Comparison of the schedule and time detail report showed time detail allocation and schedule documenting facility staff working at did not match for at least half of the dates and times. No verification of hours worked provided for agency staff listed on schedule. Interview on 1-31-17 at 4:45 p.m. with Vice President of Operations stated to remember that they had other staff in facility like the laundry person, cook, nurses, and bath aide. He/she did not provide staffing schedules or time sheets for them. Telephone interview on 2-6-17 at 10:55 a.m. with operator/licensed nurse A stated the payroll time sheets did not reflect all the staff that worked at this facility. The time sheets indicated that certified staff worked at other facilities for cost analysis. He/she did not provide time sheets for self or nurses as they do not indicate if a nurse worked in place of certified staff when short of staff. For all residents, the operator/licensed nurse failed to ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with residents FCS, HCSP and NSA when the facility failed to provide an accurate account of the staff on duty each shift.	S3245		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
S3261	Continued From page 27	S3261		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility identified a census of 22 residents. The sample included 3 residents and 4 focus review residents. Based on record review and interview for 2 (#200 and #100) of 3 residents sampled, the operator/licensed nurse failed to ensure the record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the actions taken. Findings included: - Record review for resident #200 revealed an admit date of 10-16-15 with diagnoses of dementia ,chronic obstructive pulmonary disease, hypothyroidism, anxiety, and congestive heart failure. The functional capacity screen dated 10-13-16 recorded resident required physical assistance with bathing, dressing, toileting, transfer, unable to assist with walking/mobility, management of medications or treatments, experienced short	S3261		

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	N087083	A. BUILDING: _____ B. WING _____	02/08/2017

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S3261	Continued From page 28	S3261		

term memory loss, memory recall, long term memory, decision making, impaired decision making and falls/unsteadiness.

The negotiated service agreement dated 10-13-16 recorded resident bathed two times a week, toileted regularly, assist with dressing, grooming, medication management - Licensed nursing staff will consult with physicians or primary care practitioners regarding all medication orders and ensure care givers are aware of possible side effects. A whole-body assessment will be completed by a licensed nurse within 72 hours of admission and thereafter, skin assessments will be done weekly by a certified medication aide under the supervisor of a licensed nurse. Special needs/services: briefs, oxygen, lab draws as ordered.

The Health Care Services (HCS) dated 10-13-16 recorded resident required moderate assistance with all activities of daily living, moderate assist with toileting, changing briefs, dressing, physical assist of two for transfers and one to propel in wheelchair, may crush medications and put in applesauce/pudding/jelly as resident pocket pills and will spit out. Resident oriented to person. Therapy or Treatments: "lab test, accu-checks, wound care, antibiotics, ect." 10-16-15 oxygen at 3 liters vial nasal cannula.

The HCS lacked interventions for fall risk.

The nurses notes recorded the following:

On 1-9-17 at 11:23 a.m. recorded, "fall and follow up. It was reported to this nurse at approximately 10:30 p.m. last night that resident had called out for help - upon entering resident's room, resident

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S3261	Continued From page 29	S3261		

was observed lying on fall mat, wrapped in blanket on right side, when asked resident if was OK (he/she) stated yes but (his/her) head hurt - resident presented with a hematoma on the right forehead - denied pain elsewhere - adequate range of motion for this resident - vital signs blood pressure (B/P) 158/78, pulse (P) 79, respiration (R) 16, temperature (T) 98.9. Caregivers stated that when they put resident to bed at approximately 10:15 p.m., resident was very resistive and agitated. Non-licensed neuro checks were put in place - this morning resident was up, alert at breakfast - continues to deny any pain or discomfort. Will continue to have caregivers observed and report signs/symptoms of pain or discomfort to nurse. " Signed licensed nurse A.

The record lacked a description of the hematoma to the right forehead, an assessment of the resident, follow up assessment of the injury and actions taken.

1-26-17 at 9:27 a.m. Resident has an area on the left side of his/her head that has opened and has yellow drainage. This nurse contacted medical care provider and received order for wound culture and to start Bactrim DS two times a day (antibiotic) for seven days. Order faxed to laboratory. Signed Operator/licensed nurse A.

1-30-17 No further documentation in the nurses notes.

The record lacked a description of the head wound, date and time culture obtained, and actions taken including follow up assessment.
During tour of commons area on 1-19-17 at 1:45 p.m. observed resident #200 sitting in a recliner facing the television in front of the medication

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S3261	Continued From page 30	S3261		

room. Observed large raised hematoma approximately 5 centimeters (CM) by 5 CM on right side of resident #200 ' s forehead with purple/green/yellow bruising down face and neck. The hematoma was black in color with approximately 1 CM blood blister in center. When asked what happened to his/her head , resident #200 stated he/she fell and hit head. When asked if it hurt as he/she stated it did not hurt as bad today as it did when he/she fell and hit head.

On 1-19-17 at 2:30 p.m. observed resident #200 lying back in recliner with head leaning back on head rest. The wound to back of left side/back of head was not covered and observed crusted area in hair to side/back of head in contact with the recliner head rest.

For resident #200, the record lacked documentation of the description of the head injury, actions taken, and results of actions taken. The record also lacked documentation of a description of the head wound, the date and time the culture was obtained and actions taken including follow up assessment.

- Record review for resident #100 revealed an admit date of 1-12-17 with diagnoses of dementia without behavior disturbance and arthritis.

The functional capacity screen dated 1-11-17 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, eating, unable to manage medication/treatment administration, experienced bladder incontinence, short term memory loss, memory recall, long term memory, decision making, impaired decision making, communication rarely understood, and

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S3261	Continued From page 31	S3261		

experienced falls/unsteadiness.

The negotiated service agreement dated 1-11-17 recorded resident will received three meals a day, bathing two times a week, toileting, dressing, grooming, management of medications, skin assessment completed weekly, hospice services provided.

The health care service plan dated 1-11-17 recorded resident required cueing, assistance with eating, and has difficulty chewing some meats. Resident needs assistance with all activities of daily living, hospice will provide bathing two times a week and facility staff to provide as needed. Resident is incontinent of bowel and bladder, wears briefs. Resident to use wheelchair for long distances and can ambulate short distance with assist from staff. Resident likes to go to bed around 9:00 p.m. Resident is quiet, pleasant, and cooperative. Resident takes medication whole but may crush if indicated, is oriented to self, has limited ability to express self, and hears what is said but has difficulty processing.

The nurses notes recorded the following:

On 1-12-17 at 8:18 a.m. Resident was discharged from (sister facility) and admitted to this facility yesterday afternoon. Resident arrived via private auto (by facility staff) and is adjusting to new surroundings. Staff continuing to help resident make adjustment. Signed operator/licensed nurse A.

On 1-19-17 at 4:48 a.m. There was no response to verbal or tactile stimuli. Pupils were mid-dilated and fixed. No carotid pulses were palpable. No heart sounds were auscultated.

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S3261	Continued From page 32 Resident pronounced at 1-19-17 at 12:45 a.m. Family at bedside. Hospice notified the medical care provider and mortuary. Interview on 1-19-17 at 3:55 with operator/licensed nurse A and licensed nurse B both stated and confirmed the nurses notes lacked documentation of a decline in resident's condition and the nurses notes contained one entry by operator/licensed nurse A the day after resident admitted to facility. The last entry was written by a hospice nurse (outside provider.) For resident #100, the operator/licensed nurse failed to ensure documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action taken and results of actions taken. For residents #200 and #100, the operator/licensed nurse failed to ensure the record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the actions taken.	S3261		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens;	S3305		

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S3305	Continued From page 33 (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (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 (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-207(a) The facility identified a census of 22 residents. The sample included 3 residents and 4 focus review residents. Based on observations and interviews for all residents, the operator/licensed nurse failed to ensure the provision of a safe, sanitary, and comfortable environment for residents. Findings included: - On 1-19-17 at 2:00 p.m. observed "Broadmoor"	S3305		

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S3305	Continued From page 34	S3305		

medication room. The refrigerator in the medication room had a sticky brown substance on all shelves and at base of the refrigerator and door area. Observed certified staff E put a silverware spoon in a container of liquid. Certified staff E stated they have two plastic containers, one with liquid for dirty spoons to soak in and one for clean spoons. Certified staff E stated he/she washed spoons with liquid in a plastic bottle with no label that he/she identified as soap and then dried spoons and put in a container of the medication cart to use when medications are crushed with applesauce or pudding. He/she then puts the spoon in the medication room in a container of liquid to soak. He/she stated and confirmed the spoons was washed with liquid soap and rinsed with water in the medication room on both "Broadmoor and Morningside" medication rooms. The refrigerator in medication room on "Morningside" contained a brown sticky substance on all shelves both inside and on the refrigerator door. Both medication rooms ' base boards had sticky brown substance, torn papers, and food particles on the floor. The counter tops sticky, soiled, and clutter with papers, drinks and trash overflowing.

On 1-19-17 at 2:20 p.m. licensed nurse B observed medication rooms on "Broadmoor and Morningside " and confirmed brown sticky substance in refrigerator, soiled counter top, dirty floor, and overflowing trash. Licensed nurse B stated the certified medication aides on night shift should be cleaning the medication rooms. He/she also stated the certified medication aides should be administering crushed medications to residents with a spoon, then put spoon in liquid container labeled dirty and then taken to the kitchen to be run through the dishwasher. Licensed nurse B stated and confirmed the

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S3305	Continued From page 35 containers not labeled, liquid soap not labeled and certified staff washing spoons in medication room. For all residents, the operator/licensed nurse failed to ensure the provision of a safe, sanitary, and comfortable environment for residents.	S3305		