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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for the investigation of complaint #105653 of the above residential health care facility on 10/26/16, 10/27/16, 10/31/16, and 11/1/16.	S 000		
S3120 SS=D	26-41-203 (b) Adult Day Care Services (b) Adult day care services. Any administrator or operator of an assisted living facility or residential health care facility may provide adult day care services to any individual who meets the facility ' s admission and retention criteria and receives services less than 24 hours a day if the administrator or operator ensures that all of the following conditions are met: (1) Written policies are developed and procedures are implemented for the provision of adult day care services.(2) All the requirements for admission of a resident to an assisted living facility or residential health care facility are met for an individual admitted for adult day care services. (3) At least 60 square feet of common use living, dining, and activity space is available in the facility for each resident of the facility and each resident receiving adult day care services. (4) The provision of adult day care services does not adversely affect the care and services offered to other residents of the facility. This REQUIREMENT is not met as evidenced by: KAR 26-41-203(b)(1)(2) The facility reported a census of 36 residents. The sample included 3 residents and 1 focus review resident. Based on observation, interview,	S3120		

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S3120	Continued From page 1	S3120		

and record review for 1 (#4) of 1 focus review resident, the operator/licensed nurse failed to ensure the development of written policies and implementation of procedures for the provision of adult day care services which included all the requirements for admission of a resident to a residential health care facility were met for this individual admitted for adult day care services.

Findings included:

- At 2:30 p.m. on 10/26/16, observed resident #4 sitting in a recliner in an area by the nurse's station. Certified staff B stated the resident was staying here for 2 hours while spouse went to an appointment.

At 3:15 p.m. on 10/26/16, operator/licensed nurse stated (resident #4) came to facility whenever spouse had an appointment and came in today at 11:00 a.m. and just now left to go home with spouse. Operator/licensed nurse stated he/she did not complete a functional capacity screen and develop a negotiated service agreement/health care service plan when resident admitted for adult day care. Operator/licensed nurse stated an admission agreement was not completed with the resident.

At 9:40 a.m. on 10/27/16, operator/licensed nurse provided the facility's "Day Care" policy. The policy lacked all the requirements for admission of a resident to a residential health care facility would be met for an individual admitted for adult day care services.

The operator/licensed nurse failed to ensure the development of written policies and implementation of procedures for the provision of adult day care services which included all the

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S3120	Continued From page 2 requirements for admission of a resident to a residential health care facility were met for an individual admitted for adult day care services.	S3120		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 36 residents. The sample included 3 residents. Based on record review, observation, and interview for 2 (#1, and #2) of 3 residents sampled, the operator/licensed nurse failed to provide/coordinate the provision of necessary health care services that met the needs of each resident that were in accordance with the functional capacity screen. Findings included: - Record review for resident #1 revealed an admission date of 2/1/16 and diagnoses of hypothyroidism and depression. The functional capacity screen dated 2/1/16	S3155		

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indicated the resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; was unable to perform medication management; experienced impaired short-term memory and memory recall; utilized a walker and wheelchair for mobility; and was at risk for falls.

Review of the negotiated service agreement/health care service plan (NSA/HCSP) dated 2/1/16 contained documentation of physical assistance with bathing, dressing, toileting, transferring, and mobility. The NSA/HCSP documented risk for falls with interventions of resident to ambulate with walker, staff provide stand-by assistance with walking, resident to wear appropriate footwear, avoid clutter, proper room lighting, and remind to call for assistance.

Review of the nurse's notes revealed documentation of a fall on 6/13/16 at 6:30 p.m. Operator/licensed nurse documented resident on floor with skin tear to left thumb, bruise to right forehead, and complains of pain in right wrist that was bruised and swollen. Resident stated he/she was going to bathroom. Resident sent to the emergency department for evaluation and treatment. At 9:30 p.m. on 6/13/16, operator/licensed nurse documented resident with right wrist fracture.

The NSA/HCSP lacked updated interventions related to the resident's fall with fracture of wrist.

The nurse's notes contained an entry by the operator/licensed nurse dated 8/24/16 at 8:30 p.m. that resident fell in dining room and received a laceration to right forehead. Resident transported to the emergency department and returned to facility with sutures to laceration.

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S3155	Continued From page 4 The NSA/HCSP lacked updated interventions related to the resident's fall with laceration to head. The nurse's notes contained an entry dated 6/20/16 by operator/licensed nurse that resident anxious and calling out "continually at times." This behavior continued into July 2016. On 9/23/16, operator/licensed nurse documented resident disrobing and required 1 to 1 care to keep clothed. On 10/7/16 operator/licensed nurse documented resident seen by medical care provider due to increased verbal outbursts, inappropriate language, and disrobing. The October 2016 medication administration record contained entries for resident to receive alprazolam 0.25 milligrams by mouth every 4 hours as needed for anxiety. The medication administration record contained documentation by certified medication aides that resident received 38 doses of alprazolam as needed for anxiety from 10/1/16 through 10/25/16. Certified medication aides documented "nervous" as reason for giving the medication with "less nervous" as the resident's response to the medication. At 1:10 p.m. on 10/26/16, observed resident #3 in a wheelchair mobilized by a certified staff member. Resident was singing a song repeatedly. Observed that when a staff member was not with the resident he/she called out "would somebody help me, I don't know what to do." The NSA/HCSP lacked interventions to address the resident's anxiety and behaviors. At 4:00 p.m. on 10/26/16, operator/licensed nurse	S3155		

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stated resident required 1 to 1 attention from a staff member to reduce anxiety. Operator/licensed nurse confirmed NSA/HCSP lacked interventions to reduce resident's anxiety.

At 4:30 p.m. on 10/27/16, certified staff F stated fall interventions of personal alarm, try to keep an eye on resident, and fall mat by bed. Certified staff F stated he/she provided 1 to 1 activities with resident to manage anxiety by keeping resident distracted.

The operator/licensed nurse failed to provide/coordinate the provision of necessary health care services that met the needs of resident #1 that were in accordance with the functional capacity screen.

- Record review for resident #2 revealed an admission date of 2/16/16 and diagnoses of vascular dementia, arthritis, and hypertension.

The functional capacity screen dated 10/21/16 indicated the resident was unable to perform bathing, dressing, toileting, and eating; required physical assistance with transferring and mobility; experienced impaired short-term memory, long-term memory, decision making, and memory recall; and was at risk for falls.

At 11:20 a.m. on 10/27/16, observed resident in his/her room asleep in bed. Observed resident on left side and holding onto a small rail on side of bed.

The negotiated service agreement/health care service plan dated 10/21/16 lacked documentation of the resident's use of a small bed rail including the safety of the rail and resident's ability to safely use the bed rail.

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S3155	Continued From page 6 At 3:15 p.m. on 10/26/16, licensed nurse/operator stated he/she did not assess resident's ability to safely use a bed rail or the safety of the device. The operator/licensed nurse failed to provide/coordinate the provision of necessary health care services that met the needs of resident #2 that were in accordance with the functional capacity screen.	S3155		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 36 residents.	S3200		

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The sample included 3 residents and 1 focus reviewed resident. Based on record review and interview for 3(#1, #2, and #3) of 3 residents sampled, the operator/licensed nurse failed to ensure certified medication aides administered medications in accordance with professional standards of practice.

Findings included:

- Record review for resident #1 revealed an admission date of 2/1/16 and diagnoses of hypothyroidism and depression. The functional capacity screen dated 2/1/16 indicated the resident was unable to perform medication management. The negotiated service agreement/health care service plan dated 2/1/16 documented staff administration of medications.

The October 2016 medication administration record contained entries for resident to receive alprazolam 0.25 milligrams by mouth every 4 hours as needed for anxiety and Tylenol 650 milligrams by mouth between 8:00 p.m. and 8:00 a.m. 1 time for pain. The medication administration record contained documentation by a certified medication aide on 10/10/16 that resident received Tylenol 650 milligrams. The medication administration record contained documentation by certified medication aides that resident received 38 doses of alprazolam as needed for anxiety from 10/1/16 through 10/25/16. Certified medication aides documented "nervous" as reason for giving the medication with "less nervous" as the resident's response to the medication.

The resident's record lacked documentation of a nursing assessment of the resident by a licensed nurse prior to each dose of alprazolam and the

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dose of Tylenol.

- Record review for resident #2 revealed an admission date of 2/16/16 and diagnoses of vascular dementia, arthritis, and hypertension. The functional capacity screen dated 10/21/16 indicated the resident was unable to perform management of medications. The negotiated service agreement/health care service plan dated 10/21/16 documented the service of total assistance with management of medications.

The October 2016 medication administration record contained an entry for tramadol 50 milligrams by mouth every 6 hours as needed for back pain. Certified medication aides documented 49 doses of tramadol given from 10/1/16 through 2:00 p.m. on 10/26/16. Certified medication aides documented the reason medication given as "pain" and resident response as "less pain."

The resident's record lacked documentation of a nursing assessment of the resident's pain by a licensed nurse prior to each dose of tramadol.

- Record review for resident #3 revealed an admission date of 5/23/14 and diagnoses of hypertension, depression, and agitation. The functional capacity screen dated 5/24/16 indicated the resident was unable to perform management of medications. The negotiated service agreement/health care service plan dated 5/24/16 documented service of total assistance with medication management.

The October 2016 medication administration record contained documentation of haldol 0.5 milligram by mouth or sublingual three times a day as needed for restlessness, agitation,

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delirium and ibuprofen 200 milligrams by mouth every 6 hours as needed for joint pain. Certified medication aides initialed the medication administration record of a daily dose of haldol from 10/1/16 through 10/26/16 and documented reason given as "anxious" and "less anxious" as resident ' s response. The haldol was documented as given at 7:30 a.m. every day. The medication administration record contained documentation the resident received 4 doses of ibuprofen for "pain" with resident response of "less pain."

The resident's record lacked documentation of a nursing assessment of the resident by a licensed nurse prior to each dose of haldol and the doses of ibuprofen.

At 3:00 p.m. on 10/26/16, certified staff B and certified staff E each stated they did not call the licensed nurse to assess a resident's pain and need for pain medication prior to the certified staff administering a pain medication. Certified staff B and certified staff E each stated that sometimes they called the nurse prior to administering an anti-anxiety medication and sometimes did not call the nurse prior to administering the medication.

At 3:15 p.m. on 10/26/16, operator/licensed nurse confirmed he/she did not assess residents prior to certified medication aides administering a pain medication or anti-anxiety medications ordered on an as needed basis. Operator/licensed nurse stated certified medication aides decided if resident needed the medication without contacting the nurse.

For residents #1, #2, and #3, the operator/licensed nurse failed to ensure certified

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S3200	Continued From page 10 medication aides administered medications in accordance with professional standards of practice.	S3200		
S3201 SS=E	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 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 36 residents. The sample included 3 residents and 1 focus review resident. Based on observation and interview for 13 of 14 residents receiving noon medications, the certified medication aide failed to remain with each resident while each resident ingested the medication or medications.	S3201		

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S3201	Continued From page 11 Findings included: - At 12:00 p.m. on 10/27/16, observed certified staff B (a certified medication aide) finish preparing resident medications for administration at the noon meal. Observed medication cart in the open nurse's station with a tray of medication cups sitting on top of the medication cart. At 12:10 p.m. on 10/27/16, observed certified staff B take medication cups to 14 residents in the dining room. Certified staff B observed only 1 resident ingest medications. For one resident certified staff B placed medication cup in front of resident and motioned for resident to take medications and to take a drink. Certified staff B placed medications on a spoon and put mediations in a resident's mouth and then walked away. Certified staff B went to a resident with a medication cup of medications mixed in applesauce and spooned the contents of the cup into the resident's mouth and walked away. For the remaining 10 residents, certified staff B placed a medication cup on table by each resident, walked away and did not observe each resident ingest medications.. At 12:10 p.m. on 10/27/16, certified staff B stated 14 residents received medications at the noon meal. The certified medication aide failed to remain with each resident while each resident ingested the medication or medications.	S3201		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication	S3215		

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S3215	Continued From page 12 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 expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)(1) The facility reported a census of 36 residents. The sample included 3 residents and 1 focus	S3215		

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review resident. Based on observation and interview for residents receiving medications at the evening meal 10/26/16 and residents receiving medications at the noon meal on 10/27/16, the licensed nurse/operator failed to ensure medications were stored in a locked medication room or medication cart.

Findings included:

- At 3:35 p.m. on 10/26/16, observed certified staff E at the medication cart in the open nurse's station area. Certified staff E placed a medication tray with medication cups on top of the medication cart and began placing medications in the cups. Certified staff E left the area with the medications on top of the medication cart and the medication cart unlocked 3 times during the observation. Certified staff E left to go to the facility kitchen, to go outside with a resident, and then into medication room with each of these areas out of sight of medication cart.

At 3:50 p.m. on 10/26/16, informed operator/licensed nurse that medications were left unattended on top of medication cart. Operator/licensed nurse went to medication room and spoke with certified staff E who came and locked medication cart and took tray of medications to lock in medication room.

At 12:00 p.m. on 10/27/16, observed certified staff B finish preparing resident medications for administration at the noon meal. Observed medication cart in the open nurse's station with a tray of medication cups sitting on top of the medication cart. Certified staff B left the medications unattended two times to go into the dining room to take blood pressure for two residents and was not able to observe cart.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3215	Continued From page 14 At 12:10 p.m. on 10/27/16, certified staff B stated 14 residents received medications at the noon meal. Licensed nurse/operator failed to ensure medications were stored in a locked medication room or medication cart.	S3215		
S3320 SS=E	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254(a)	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	11/01/2016

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S3320	Continued From page 15 The facility reported a census of 36 residents. The sample included 3 residents and 1 focus review resident. Based on observation, interview, and record review for all residents living in the facility, the operator/licensed nurse failed to ensure the maintenance of the facility to protect the health and safety of residents. Findings included: - Observations during tour included: Housekeeping cart stored in the utility room in the north hall. No locking device present on door to utility room. Four plastic refillable spray bottles with one bottle labeled Pine-sol disinfectant, one labeled bleach water, one labeled odor neutralizer, and one labeled carpet cleaner; spray can of Scrubbing Bubbles; Lysol toilet bowl cleaner; glass cleaner; and Comet powder stored on housekeeping cart. Operator/licensed nurse stated housekeeping cart usually stored in janitor closet in south hall. Went with operator/licensed nurse to the janitor closet in the south hall and observed the door did not have a doorknob. Operator/licensed nurse stated the doorknob was to be replaced and confirmed the door would not lock. In this closet observed two 1-gallon bottles of Pine-sol, 1-gallon bleach, Lysol spray, six containers of toilet bowl cleaner, odor neutralizer, furniture polish, and Comet powder. Men's shower room in the south hall observed a plastic spray bottle labeled "Odo-Ban showers" hanging on shower curtain rod. Operator/licensed nurse stated this spray used to disinfect the shower.	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3320	Continued From page 16 At 9:45 a.m. on 10/27/16 housekeeper C stated he/she stored his/her cleaning cart in the utility room in the north hall and would from now on be removing chemicals from cart when cart not in use. At 9:50 a.m. on 10/27/16 housekeeper D stated he/she stored his/her cleaning cart in the janitor closet in the south hall. Review of the resident roster revealed 16 of the 36 residents experienced impaired cognition. The operator/licensed nurse failed to ensure the maintenance of the facility to protect the health and safety of residents.	S3320		