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	B089080	A. BUILDING: _____ B. WING _____	06/10/2014

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S 000	INITIAL COMMENTS The following citations represent the findings of an initial survey at the above named home plus facility conducted on 6-4-14, 6-5-14, 6-9-14 and 6-10-14.	S 000		
S5028 SS=D	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	S5028		

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

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S5028	Continued From page 1 KAR 26-42-101(f)(3) The facility reported a census of 3 residents. The sample included 3 residents. Based on record review and interview for 1 (#540) of 3 sampled residents, the operator failed to ensure all allegations of abuse, neglect or exploitation were reported to the department within 24 hours, and immediate measures were taken to prevent further potential abuse, neglect or exploitation. Findings included: - Record review for resident #540 revealed admission on 6-30-13 with diagnoses Bipolar, Depressed with Psychotic Behavior, Osteoarthritis, Insomnia due to Mental Disorder, Allergic Rhinitis, Stress Incontinence and Hypothyroidism. The Functional Capacity Screen dated 6-30-13 recorded resident independent with bathing dressing, toileting, transfers and eating; supervision with medication and treatment management. Continent of bladder. Cognition: problems with decision-making. No problems with communication. The Negotiated Service Agreement dated 6-30-13 recorded services for a regular diet, medication assistance and escort to medical appointments. The NSA lacked health care services to address the resident's elopement risk. Nurses Notes recorded the following: 7-18-13 (no time documented): "Went to a group meeting at the hospital and took off from meeting never returning or calling the facility. Operator notified resident's family member, was called around 4:45 pm. Family member said it was	S5028		

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S5028	Continued From page 2	S5028		

resident' birthday and maybe his/her other children had talked to resident. The family member later called and said no luck. He/She pleaded with us from the first time we spoke to not call the police. We said it's in our protocol to do so...Resident later showed up to the hospital and said he/she had alcohol and wanted to be admitted. We have kept in contact with resident's nurse from the hospital." 7-22-13 (no time documented): "Spoke with resident briefly, he/she still not feeling well. I, certified staff D, spoke with resident's nurse 7-19-13 and 7-22-13 several times both day." Signed by certified staff D.

No Date: "Returned to facility at 4:00 pm 7-24-13. " Signed by certified staff D.

9-5-13 at 11:00 am: "Resident said he/she was going to coffee shop downtown by bus. He/She did not come back for lunch nor dinner. Was called several times on his/her cell phone but no answer. Final medication pass was at 7:45 pm that Thursday night and still no show. Resident's family was called some time around dinner. He/She said hadn't heard from resident and would try his/her phone and other family member. The family member said maybe resident would be home by 9:00 pm and to give resident until then and call back. In the meantime, I, certified staff D, called 911 to report him/her as a wanderer or missing resident. Gave the police resident's description and age. They said they would call us back and bring resident here if found. No word from police or resident.

9-6-13 (no time documented): Friday morning around 8:00 am resident's family came by to ask if any lead. We said hadn't heard from him/her or police. Around 11:00 am a staff member that

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S5028	Continued From page 3	S5028		

was downtown called and said they seen resident walking around downtown. They said he/she waved at them and kept walking. The facility then notified the police with his location so they could pick him/her up and take him/her to the hospital to be checked out since he/she had substance abuse in the past. The police never called.

9-7-13 (no time documented): "I, certified staff D, had our other staff member call the police for missing persons. They came over and made a report. the police did not find him/her but resident's family member called later at 3:30 and said resident had called and asked to be picked up. They brought the resident to facility and staff told them to take resident to the hospital to be evaluated since resident was off his/her medications and we did not know if resident was under the influence of drugs or alcohol. Resident then left with family member."

9-8-13 (no time documented): "No word from resident or family member."

9-9-13 (no time documented): "Resident's family member took resident to hospital to see case worker who is also resident's nurse there. They said they could not admit resident so he/she was brought to facility around 9:00 am where he/she received medications. We all had a sit down conference with operator, resident's family member, resident and certified staff D. We thought we made some head way but resident still had a serious attitude and made comments of not knowing what he/she wanted and he's/she's almost 60 years old." Signed by certified staff D.

9-24-13 (no time documented): "Certified staff D took resident to get shot of Risperdone at the hospital at 9:30 am that Tuesday morning. Then

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S5028	Continued From page 4	S5028		

we came back and later he/she had lunch. I then took him/her to a 1:30 hair appointment where I picked him/her up from. He/she said wanted to go for a walk. He/She never came home for supper so we called his/her family member and the authorities later that evening around 9:00 pm. We called his/her phone several times no answer. Resident called his/her lawyer and was given $200.00 by him/her. Resident then stayed gone til Sunday morning at 8:45 am. So, he/she was taken to the hospital where he/she admitted to doing speed and marijuana. The nurse said they would admit him/her." Monday 9-30-13 (no time documented): "We were called to pick him/her up at the hospital. I picked him/her up at 3:30 pm so he/she is here at the facility."

Interview on 6-4-14 at 5:59 pm with certified staff D confirmed the resident's above incidents were not reported to the department. Further confirmed the nurse failed to initiate health care services to address resident's risk for elopement.

Interview on 6-9-14 at 11:57 am with licensed nurse B confirmed he/she did not perform an assessment on the resident when he/she returned to the facility from the hospital on 7-24-13, nor did he/she implement health care services to address resident's elopement risk. Further stated he/she was not aware resident had eloped again in September 2013.

For resident #540, the operator failed to ensure all allegations of abuse, neglect or exploitation were reported to the department within 24 hours, and failed to provide services to the resident with impaired decision-making to prevent further abuse, neglect or exploitation after the resident eloped initially then experienced 2 subsequent elopements.

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S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus 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 26-42-204(a) The facility reported a census of 3 residents. The sample included 3 residents. Based on record review and interview for 1 (#540) of 3 sampled residents, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident and addressed the resident's risk for elopement. Findings included: - Record review for resident #540 revealed admission on 6-30-13 with diagnoses Bipolar, Depressed with Psychotic Behavior, Osteoarthritis, Insomnia due to Mental Disorder, Allergic Rhinitis, Stress Incontinence and Hypothyroidism. The Functional Capacity Screen dated 6-30-13 recorded resident independent with bathing dressing, toileting, transfers and eating; supervision with medication and treatment	S5155		

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S5155	Continued From page 6	S5155		

management. Continent of bladder. Cognition: problems with decision-making. No problems with communication.

The Negotiated Service Agreement dated 6-30-13 recorded services for a regular diet, medication assistance and escort to medical appointments. The NSA identified licensed nurse B as the nurse responsible for the implementation and supervision of nursing plan. The NSA lacked health care services to address the resident's elopement risk.

Nurses Notes recorded the following:
7-18-13 (no time documented): "Went to a group meeting at the hospital and took off from meeting never returning or calling the facility. Operator notified resident's family member, was called around 4:45 pm. Family member said it was resident' birthday and maybe his/her other children had talked to resident. The family member later called and said no luck. He/She pleaded with us from the first time we spoke to not call the police. We said it's in our protocol to do so...Resident later showed up to the hospital and said he/she had alcohol and wanted to be admitted. We have kept in contact with resident's nurse from the hospital." 7-22-13 (no time documented): "Spoke with resident briefly, he/she still not feeling well. I, certified staff D, spoke with resident's nurse 7-19-13 and 7-22-13 several times both day." Signed by certified staff D.

No Date: "Returned to facility at 4:00 pm 7-24-13. " Signed by certified staff D. The record lacked documentation of an assessment by a licensed nurse upon return from the hospital to examine the resident for any injuries (per facility policy); and to evaluate resident's safety

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S5155	Continued From page 7	S5155		

awareness and determine whether he/she could be away from the facility unattended.

9-5-13 at 11:00 am: "Resident said he/she was going to coffee shop downtown by bus. He/She did not come back for lunch nor dinner. Was called several times on his/her cell phone but no answer. Final medication pass was at 7:45 pm that Thursday night and still no show. Resident's family was called some time around dinner. He/She said hadn't heard from resident and would try his/her phone and other family member. The family member said maybe resident would be home by 9:00 pm and to give resident until then and call back. In the meantime, I, certified staff D, called 911 to report him/her as a wanderer or missing resident. Gave the police resident's description and age. They said they would call us back and bring resident here if found. No word from police or resident.

9-6-13 (no time documented): Friday morning around 8:00 am resident's family came by to ask if any lead. We said hadn't heard from him/her or police. Around 11:00 am a staff member that was downtown called and said they seen resident walking around downtown. They said he/she waved at them and kept walking. The facility then notified the police with his location so they could pick him/her up and take him/her to the hospital to be checked out since he/she had substance abuse in the past. The police never called.

9-7-13 (no time documented): "I, certified staff D, had our other staff member call the police for missing persons. They came over and made a report. the police did not find him/her but resident's family member called later at 3:30 and said resident had called and asked to be picked up. They brought the resident to facility and staff

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told them to take resident to the hospital to be evaluated since resident was off his/her medications and wd did not know if resident was under the influence of drugs or alcohol. Resident then left with family member."

9-8-13 (no time documented): "No word from resident or family member."

9-9-13 (no time documented): "Resident's family member took resident to hospital to see case worker who is also resident's nurse there. They said they could not admit resident so he/she was brought to facility around 9:00 am where he/she received medications. We all had a sit down conference with operator, resident's family member, resident and certified staff D. We thought we made some head way but resident still had a serious attitude and made comments of not knowing what he/she wanted and he's/she's almost 60 years old." Signed by certified staff D.

9-24-13 (no time documented): "Certified staff D took resident to get shot of Risperdone at the hospital at 9:30 am that Tuesday morning. Then we came back and later he/she had lunch. I then took him/her to a 1:30 hair appointment where I picked him/her up from. He/she said wanted to go for a walk. He/She never came home for supper so we called his/her family member and the authorities later that evening around 9:00 pm. We called his/her phone several times no answer. Resident called his/her lawyer and was given $200.00 by him/her. Resident then stayed gone until Sunday morning at 8:45 am. So he/she was taken to the hospital where he/she admitted to doing speed and marijuana. The nurse said they would admit him/her." Monday 9-30-13 (no time documented): "We were called to pick him/her up at the hospital. I picked

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S5155	Continued From page 9 him/her up at 3:30 pm so he/she is here at the facility." Signed by certified staff D. The record lacked documentation of an assessment by a licensed nurse upon return from the hospital to examine the resident for any injuries (per facility policy); and to evaluate resident's safety awareness and determine whether he/she could be away from the facility unattended. Interview on 6-4-14 at 5:59 pm with certified staff D confirmed the nurse failed to initiate health care services to address resident's risk for elopement. Interview on 6-9-14 at 11:57 am with licensed nurse B confirmed he/she conducted the functional capacity screening and completed the negotiated service agreement. Stated he/she did not speak with the resident or perform an assessment when the resident returned from the hospital in July of 2013 and did not speak with the physician. Confirmed he/she did not implement changes in the resident's health care services to address his/her elopement behaviors. Stated he/she was not aware resident had eloped again in September of 2013. For resident #540, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident and addressed the resident's risk for elopement when the resident failed to return to the facility in July of 2013 then eloped twice in September of 2013.	S5155		
S5161 SS=D	26-42-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed	S5161		

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S5161	Continued From page 10 nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(d) The facility reported a census of 3 residents. The sample included 3 residents. Based on record review and interview for 1 (#623) of 3 sampled residents, the operator failed to ensure the negotiated service agreement contained a description of health care services to be provided for management of diabetes. Findings included: - Record review for resident #623 revealed admission on 6-30-14 with diagnoses Schizophrenia Paranoid with Personality Disorder, Hyperlipidemia, Diabetes Mellitus Hypertension, Congestive Heart Failure, Gastroesophageal Reflux Disorder and Obstructive Chronic Rhinitis. The Functional Capacity Screen dated 6-30-14 recorded resident required supervision with medication management. The Negotiated Service Agreement (NSA) dated 6-30-14 recorded facility to provide medication assistance. The NSA lacked documentation of who is responsible for management of diabetes including blood glucose monitoring and insulin administration. Review of Medication Administration Record for June 2013 revealed: Gargine Insulin 100 u/ml (units per milliliter) Inject 45 units subcutaneously at bedtime for Diabetes	S5161		

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S5161	Continued From page 11 Management. Documentation of administration of the insulin was initialed by certified staff D. Accuchecks four times a day before meals and at bedtime initialed as completed by certified staff D. Interview on 6-4-14 at 10:50 am with certified staff D stated resident self administers insulin and he/she (certified staff D) supervises his/her performance of accuchecks (blood glucose monitoring): stated, "I help him/her do it.". Confirmed the NSA lacked documentation of who is responsible for diabetes management including administration of insulin and performance of accuchecks. For resident #623, the operator failed to ensure the negotiated service agreement contained a description of health care services to be provided for management of diabetes.	S5161		
S5165 SS=F	26-42-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(e) The facility reported a census of 3 residents. The sample included 3 residents. Based on record review and interview for 1 (#623) sampled resident requiring " accuchecks " (blood sugar monitoring with a glucometer), a nursing	S5165		

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procedure not included in the medication aide curriculum, the operator failed to ensure the licensed nurse delegated the procedure to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.

Findings included:

- Record review for resident #623 revealed admission on 6-30-14 with diagnoses Schizophrenia Paranoid with Personality Disorder, Hyperlipidemia, Diabetes Mellitus Hypertension, Congestive Heart Failure, Gastroesophageal Reflux Disorder and Obstructive Chronic Rhinitis.

The Functional Capacity Screen dated 6-30-14 recorded resident required supervision with medication management. The Negotiated Service Agreement (NSA) dated 6-30-14 recorded facility to provide medication assistance.

Review of Medication Administration Record for June 2013 revealed:
Accuchecks (blood glucose monitoring) four times a day before meals and at bedtime initialed as completed by certified staff D.

Review of personnel record for certified staff D revealed the record lacked documentation of education or assessment of competency by a licensed nurse for delegation of blood sugar monitoring with a glucometer.

Interview on 6-4-14 at 10:50 am with certified staff D stated resident he/she (certified staff D) supervises resident's performance of accuchecks (blood glucose monitoring with a glucometer): stated, "I help him/her do it." Further stated

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S5165	Continued From page 13 he/she had been instructed by a nurse at the hospital regarding performance of accuchecks. Confirmed the facility nurse did not check him/her to verify competency. The operator failed to ensure the licensed nurse delegated blood sugar monitoring with a glucometer to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S5165		
S5215 SS=E	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d) The facility reported a census of 3 residents. The sample included 3 residents. Based on record review and interview for all residents and staff,	S5215		

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S5215	Continued From page 14 the operator failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly reviews of the home's emergency management plan with residents and staff. Findings included: - Review of the home's emergency management plan on 6-4-14 at 3:35 pm with certified staff D revealed review with the staff as follows: 2-10-13: Power Outages 6-9-13: Storms 7-8-13: Evacuation 8-8-13: Shelter Location 9-1-13: If flood to highest point 2-1-14: Winter Storms, Power Outages 3-1-14: Gas Outages 4-1-14: Tornado The plan lacked documentation of quarterly review of all components of the emergency management plan with staff and quarterly review with the residents. Interview on 6-4-14 at 3:45 pm with certified staff D confirmed no system in place for quarterly review of the emergency management plan with the residents and further confirmed no further documentation of review with the staff to include all components of the plan quarterly. For all staff and residents, the operator failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly reviews of the home's emergency management plan with residents and staff.	S5215		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies	S5230		

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S5230	Continued From page 15 (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; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-207(b)(6)(c) The facility reported a census of 3 residents. The sample included 3 residents. Based on record review and interview for 3 (#452, #540, #623) of 3 sampled residents and 1 (certified staff C) of 1 newly hired staff, the operator failed to ensure the home's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Record review for resident #452 revealed admission on 4-8-13. Record documented a single view chest x-ray dated 1-28-13: "No acute process within the chest." The record lacked documentation of a tuberculosis (TB) symptom screen and a 2 view chest x-ray. Interview on 6-4-14 at 5:00 pm with certified staff	S5230		

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S5230	Continued From page 16 D confirmed the record lacked documentation of a 2 view chest x-ray. - Record review for resident #540 revealed admission on 6-30-14. TB skin test results dated 7-5-13: "negative"; and 7-28-13 "negative". The record lacked documentation of skin test results in mm (millimeters) of induration. Interview on 6-4-14 at 5:46 pm with certified staff D confirmed the TB skin test results were not read in mm of induration. - Record review for resident #623 revealed admission on 6-30-14. TB skin test results dated 7-5-13: "negative"; and 7-28-13 "negative". The record lacked documentation of skin test results in mm of induration. Interview on 6-4-14 at 5:46 pm with certified staff D confirmed the TB skin test results were not read in mm of induration. Personnel record reviewed on 6-4-14 for Certified staff C with date of hire 10-15-13. Record lacked documentation of a TB questionnaire or a 2-step TB skin test. Interview on 6-4-14 at 7:23 pm with certified staff D confirmed the record lacked a TB questionnaire or a 2 step TB skin test. For residents #452, #540, #623 and certified staff C, the operator failed to ensure the home's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S5230		

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S5265	Continued From page 17	S5265		
S5265 SS=D	26-42-205 (a) (1) Medication Self Administration Assessment (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(a)(1) The facility reported a census of 3 residents. The sample included 3 residents. Based on record review and interview for 1 (#623) of 3 sampled residents, the operator failed to ensure the licensed nurse performed an assessment to determine the resident could self-administer medications safely and accurately and without staff assistance; and failed to ensure this assessment was completed initially before the resident began self-administration of insulin and inhaler.	S5265		

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S5265	Continued From page 18 Findings included: - Record review for resident #623 revealed admission on 6-30-14 with diagnoses Schizophrenia Paranoid with Personality Disorder, Hyperlipidemia, Diabetes Mellitus Hypertension, Congestive Heart Failure, Gastroesophageal Reflux Disorder and Obstructive Chronic Rhinitis. The Functional Capacity Screen dated 6-30-14 recorded resident required supervision with medication management. The Negotiated Service Agreement (NSA) dated 6-30-14 recorded facility to provide medication assistance. Review of Medication Administration Record and physician's orders revealed: Gargine Insulin 100 u/ml (units per milliliter) Inject 45 units subcutaneously at bedtime for Diabetes Management. Albuterol/Ipratropium 100/20 mg/mcg (milligrams per micrograms) inhaler, 1 puff four times per day as needed for shortness of breath. Not to use more than 6 puffs per day. Interview on 6-4-14 at 6:47 pm with certified staff D stated resident "takes it (inhaler) everyday when he/she needs it" and self administered insulin. Interview on 6-5-14 at 10:50 am with certified staff D confirmed resident self administers insulin stated, "he/she draws up it (insulin) up" and self injects, "usually take it in his/her stomach." Confirmed the record lacked a self-administration of medication assessment performed by a licensed nurse stated, "we've never had that paperwork."	S5265		

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S5265	Continued From page 19 For resident #623, the operator failed to ensure the licensed nurse performed an assessment to determine the resident could self-administer medications safely and accurately and without staff assistance; and failed to ensure this assessment was completed initially before the resident began self-administration of insulin and use of inhaler.	S5265		
S5380 SS=E	28-39-437 Plumbing and Piping Systems (i) Plumbing and piping systems. (1) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (2) Water distribution systems shall be arranged to provide hot water at hot water outlets at all times. The temperature of hot water shall range between 98° F and 120° F at showers, tubs, and lavatories accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(i)(2) The facility reported a census of 3 residents. The sample included 3 residents. Based on observation and interview for all residents, the operator failed to ensure the temperature of hot water shall range between 98 degrees Fahrenheit and 120 degrees Fahrenheit at showers, tubs and lavatories accessible to residents. Findings included: - Observation on 6-4-14 at 4:38 pm during entrance tour of facility revealed kitchen sink hot water temperature at 146.3 degrees Fahrenheit.	S5380		

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S5380	Continued From page 20 Observed 1 hot water tanks in basement which operator identified as the tank for the kitchen. Operator adjusted the thermostat on this tank and drained water from tank to lower hot water temperature. Recheck of hot water temperatures on 6-4-14 at 6:22 pm revealed a temperature of 111.7 degrees Fahrenheit. The resident roster identified no residents with impaired cognition. Observations during survey revealed no residents going to the kitchen. Interview on 6-4-14 at 2:35 pm with operator stated the temperatures were "monitored" but confirmed the facility lacked a policy and system for regular monitoring and documentation of hot water temperatures. Also stated the residents "don't come in here." For all residents, the operator failed to ensure the temperature of hot water shall range between 98 degrees Fahrenheit and 120 degrees Fahrenheit at showers, tubs and lavatories accessible to residents.	S5380		