STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089041	A. BUILDING: _____ B. WING _____	08/25/2022

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LEXINGTON PARK ASSISTED LIVING	1021 SW FLEMING COURT TOPEKA, KS 66604

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaint investigations, #161997, #167190, #167224, at the above named assisted living facility conducted on 08/23/22, 08/24/22, 08/25/22.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a)(1)(2) The facility reported a census of 55 residents (R). The sample included three residents, one focused record review and one closed record review. Based on observation, interview, and	S3085		

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

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record review for one (R823) of three sampled residents and one (R827) focused record review, the operator failed to ensure designated staff completed the Negotiated Service Agreement/Health Care Service Plan to include a description of the services the resident will receive and identification of the provider of each service provided to the resident.

Findings included:

- Review of R823's medical record revealed she moved into the facility on 05/06/22 with diagnoses of esophageal obstruction and had a gastrostomy tube (tube inserted through the belly that brings nutrition directly to the stomach)

On 08/25/22 at 08:44 AM "Administrative Staff" A confirmed the facilities "Functional Capacity Screen", and "Negotiated Service Agreement" (FCS/NSA) was all one document.

R823's FCS/NSA identified the resident needed physical assistance with eating, received supplements and had a mechanically altered diet. The resident's FCS/NSA failed to identify that Certified Medication Aides prepared the resident's medications, tube feeding, and free water and assisted the resident with pouring the medications and feeding into her gastrostomy tube (G-tube).

On 08/24/22 at 12:30 PM "Administrative staff" A and "Administrative staff" E confirmed the resident had a G-tube and could eat pleasure foods that were of pureed consistency. Staff A stated one condition for her to be able to come back to assisted living was for her to be able to

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do her own bolus feeding and free water.

Observation on 08/24/22 at 07:50 PM "Certified Medication Aide" (CMA) D went to the resident's room to help her with her bedtime medications and tube feeding. CMA D got her pills out of the cabinet and crushed them. He then added water to the cup so that it was full and stirred the crushed medications. He then got a graduate out of the cabinet and filled it with 300 cubic centimeters (cc) of water and then in another graduate poured one container of the isosource supplement. He took the supplies over to where the resident sat and proceeded to help the resident with setting things up. He opened the top of the G-tube and placed the syringe in it and asked her if she could hold it (syringe and tubing) and R823 said she could. CMA D then proceeded to pour water in the top of the syringe, then poured the medication in the tubing and let it drain, and then poured water in the syringe until about half full. CMA D then poured the Isosource supplement into the G-tube, added some water, then continued to pour the Isosource until it was gone. CMA D followed up the Isosource with the remaining water which was over 60 cc.

At 08:15 PM on 08/24/22 as CMA D had finished giving the resident her medications and tube feeding "Administrative Staff" E came into the resident's room. Staff and Surveyor left the resident's room and Administrative Staff E asked how the resident did giving her own tube feeding. Surveyor explained CMA D completed the whole task except the resident held the syringe, and tubing for staff to pour into. Administrative Staff E stated the resident needed to do the task

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independently as that was part of her condition for being able to return to assisted living.

On 08/24/22 at 2:00 PM "Administrative Staff" A confirmed the residents FCS/NSA did not identify that Facility staff prepared the resident's bedtime medications and G-tube feeding and that the resident was supposed to pour the medications, feedings, and water into the G-tube independently.

The operator failed to ensure designated staff included a description of all services the resident would receive and identification of the provider for services related to administration of G-tube feedings and medications.

- Review of R827's medical record revealed she moved into the facility on 09/23/22 with diagnoses of depression, heart disease and spinal stenosis.

On 08/25/22 at 08:44 AM "Administrative Staff" A confirmed the facilities "Functional Capacity Screen", and "Negotiated Service Agreement" (FCS/NSA) was all one document.

R827's FCS/NSA failed to identify that the resident had electronic monitoring in her room that transmitted outside of the facility.

On 08/25/22 at 01:55 PM "Administrative staff" A confirmed the residents FCS/HCSP did not identify that the resident had approved electronical monitoring system in her room.

Review of the undated "Negotiated Service Agreement and Health Service Plan" policy

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S3085	Continued From page 4 revealed the Negotiated Service Agreement shall provide a description of the services the resident will receive and identification of the provider of each service. The operator failed to ensure designated staff included the electronical monitoring system in the resident's room in her FCS/NSA. The operator failed to ensure R823's FCS/NSA included a description of the services the resident would receive regarding her G-tube feedings.	S3085		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced	S3280		

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S3280	Continued From page 5 by: KAR 26-41-104(d)(3) The facility reported a census of 55 residents. Based on record review and interview for all residents and all facility employees, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with residents. Findings included: - On 08/24/22 at 01:00 PM "Administrative Staff" A reported the emergency management plan was reviewed with residents during resident council. Review of the resident council minutes revealed that on 12/2021 and 06/06/22 on the cover page it had handwritten review of emergency plan. There was no additional evidence in the resident council minutes that the emergency management plan had been reviewed with residents. On 08/24/22 at 01:15 PM "Activity Staff " B reported "Maintenance Staff" C gathers with the residents in the main living room and goes over the emergencies and he kept track of that meeting. On 08/24/22 at 01:32 PM "Administrative Staff" A spoke with maintenance staff C, and he stated he did not review the emergency management plan with residents. "Administrative Staff" A confirmed the plan needed to be reviewed quarterly with all residents. The operator failed to ensure designated staff	S3280		

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S3280	Continued From page 6 reviewed the emergency management plan quarterly with all residents.	S3280		
S3305 SS=E	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; (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.	S3305		

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S3305	Continued From page 7 This REQUIREMENT is not met as evidenced by: KAR 26-41-207 (b)(4) The facility reported a census of 55 residents. Based on observations and interview the operator failed to ensure staff implemented procedures to prevent the spread of infections by the failure to ensure staff handled glasses and coffee cups properly Findings included: - Observation on 08/25/22 at 12:09 PM "Dietary Staff" F had on gloves and had been filling water glasses and passing out plates to residents. She gathered napkins and picked up two water glasses by putting her fingers in the water glass and taking them to the sunroom to a resident and her visiting family. Dietary Staff F continued to serve other residents with the same gloves on. She went into the kitchen touching the door handle and brought out a coffee pot and proceeded to pick up residents' coffee cups by the rim where residents would drink from. She then went back into the kitchen and got a pitcher of water and proceeded to fill resident water glasses by picking them up by the rim as well without ever changing her gloves. On 08/25/22 at 12:30 PM "Dietary Staff" G stated staff were supposed to pick coffee cups and glasses by the bottom and not the rim where residents drink from.	S3305		

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S3305	Continued From page 8 Review of the facility's "Storing Utensils, Tableware, and Equipment" policy revised on 04/27/20 directed staff that cups, glasses, and similar items should be handled so as not to touch any surface that may encounter food or a resident's mouth The administrator failed to ensure dietary staff served foods using techniques to ensure the prevention of the spread of infections by the failure of staff to use proper glove usage when handling ready to eat foods.	S3305		
S9999	Final Observations Kansas Statute 39-981. Authorized electronic monitoring; reasonable accommodations; notice; consent; use as evidence; prohibitions. (d) A resident, or such resident's guardian or legal representative, who wishes to conduct authorized electronic monitoring shall notify the adult care home on a form prescribed by the secretary for aging and disability services. (i) Each adult care home shall post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents. This Requirement is not met as evidenced by: Scope and Severity of E.	S9999		

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The facility reported a census of 55 residents. The sample included three residents, 1 focused record review and 1 closed record review. Based on observation, record review, and interview for all residents who had electronic monitoring devices in their rooms, the operator failed to ensure the state required paperwork was completed for the use of video surveillance for one (R827) of one focused review and two other resident's who had electronic monitoring devices in their rooms.

Findings included:

- Review of R827's record revealed she moved into the facility on 09/23/19 with diagnoses of spinal stenosis and heart disease.

R827's "Functional Capacity Screen/ Negotiated Service Agreement" dated 02/28/22 revealed the resident was independent with her activities of daily living.

Observation on 08/25/22 at 11:38 AM R827 had two cameras in her living room.

On 08/25/22 at 01:55 PM "Administrative Staff" A reviewed the paperwork that R827's legal representative completed regarding having electronic monitoring in the resident's room. Staff A acknowledged the paperwork did not contain the "Request for Authorized Electronic Monitoring" forms as required by the state. Administrative staff A reviewed R828 and R829's electronic paperwork and acknowledge they too, did not have the Request for Authorized Electronic Monitoring paperwork.

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S9999	Continued From page 10 Review of the "Procedure for Electronic Monitoring Disclosure" updated on 10/23/18 revealed Permission and disclosure documents must be signed by the resident and resident's family. The facility failed to ensure the proper paperwork was completed for the use of a recording camera in the resident's room concerning video surveillance was in use within the facility.	S9999		