STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B076002	A. BUILDING: _____ B. WING _____	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH WIND HOME	496 YUCCA LANE PRATT, KS 67124

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey for the above named Home Plus Facility conducted on 12/27,28/2022.	S 000		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus 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 26-42-202(a)(1)(2) The facility reported a census of 12 residents(R). The sample included three residents. Based on observation, interview, and record review for three (R3, R4, R5) of three sampled residents the operator failed to ensure designated staff developed a "Negotiated Service Agreement" based on the resident's "Functional Capacity Screen" and service needs, which include a	S5105		

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

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S5105	Continued From page 1	S5105		

description of all the services the resident would receive and the provider of those services.

Findings included:

- Review of R3's medical record revealed she moved into the facility on 07/23/21with diagnoses of diabetes mellitus type II and blindness.

R3's "Functional Capacity Screen" (FCS) dated 01/25/22 revealed the resident required physical assistance with bathing, dressing and toileting, was unable to manage her medications and medical treatments. It also identified she had bladder incontinence and impaired vision.

R3's "Negotiated Service Agreement" (NSA) dated 01/25/22 failed to include services related to impaired vision. The NSA identified the "staff" would assist resident with bathing, dressing, and toileting and "staff" would perform medication management and monitor glucose monitoring seven days a week. The NSA failed to specify "who" provided the service as not all facility "staff" are qualified to provide assistance with activities of daily living or manage medications and medical treatments. It also failed to identify the "Certified Medications Aide" dialed the resident's insulin pen to the ordered dosage and the resident self-injected the insulin.

On 12/28/22 at 11:16 AM "Licensed Nurse" B acknowledged the NSA did not specify that only certain staff could provide services related to activities of daily living and medication administration/medical treatments. She also acknowledged the NSA did not include the cueing and verbal communication staff do related

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S5105	Continued From page 2	S5105		

to her blindness.

Review of the undated "Negotiated Service Agreement" policy revealed the NSA would include the service the resident would receive and who would provide the service.

The operator failed to ensure designated staff developed R3's NSA according to the functional needs identified in the FCS and who would provide the services.

- Review of R4's medical record revealed she moved into the facility on 11/06/21with diagnoses of multiple sclerosis, and diabetes mellitus, and history of pressure ulcers.

R4's "Functional Capacity Screen" (FCS) dated 01/25/22 identified the resident was unable to perform all activities of daily living (ADL) except she was independent with eating and was unable to manage her medications or medical treatments. It also noted "see MAR" (Medication Administration Record) for ordered treatments.

R4's "Negotiated Service Agreement" dated-1/25/22 identified "staff" performed bathing, dressing, toileting, transfers and mobility for resident and "Staff" perform management of medications seven days per week and performed wound care as needed. The NSA failed to identify "who" provided these services as not all "staff" are qualified to perform ADL care, manage medications, or perform wound care.

On 12/28/22 at 11:16 AM "Licensed Nurse" B acknowledged the NSA did not specify that only certain staff could provide services related to

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S5105	Continued From page 3 activities of daily living and medication administration/medical treatments. Review of the undated "Negotiated Service Agreement" policy revealed the NSA would include the service the resident would receive and who would provide the service. The operator failed to ensure designated staff developed R4's NSA according to the functional needs identified in the FCS and who would provide the services. - Review of R5's medical record revealed he moved into the facility on 04/02/22 with diagnoses of hypertension, heart failure and dementia. R5's "Functional Capacity Screen" (FCS) dated 04/02/22 revealed the resident needed physical assistance with all activities of daily living except for eating and needed physical assistance with medications and medical treatments. It also identified the resident had impaired cognition and impaired decision making. R5's "Negotiated Service Agreement" dated 04/02/22 failed to include services related to medical treatments, impaired cognition and impaired decision making. It identified "staff" assisted with bathing, dressing, toileting, transfers and mobility for resident and "Staff" perform management of medications seven days per week. The NSA failed to identify "who" provided these services as not all "staff" are qualified to perform ADL care or manage medications.	S5105		

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S5105	Continued From page 4 On 12/28/22 at 11:16 AM "Licensed Nurse" B acknowledged the NSA did not specify that only certain staff could provide services related to activities of daily living and medication administration/medical treatments. Review of the undated "Negotiated Service Agreement" policy revealed the NSA would include the service the resident would receive and who would provide the service. The operator failed to ensure designated staff developed R5's NSA according to the functional needs identified in the FCS and who would provide the services.	S5105		
S5116	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(2)	S5116		

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S5116	Continued From page 5 The facility reported a census of 12 residents (R). The sample included three residents. Based on observation, interview and record review the operator failed to ensure the review and if necessary, the revision of the negotiated service agreement for one (R5) of three sampled residents following any significant change in condition, as defined in KAR 26-39-100. Findings Included: - Review of R5's medical record revealed he moved into the facility on 04/02/22 with diagnoses of hypertension, heart failure and dementia. R5's "Functional Capacity Screen" (FCS) dated 04/02/22 revealed the resident needed physical assistance with all activities of daily living except for eating and needed physical assistance with medications and medical treatments. It also identified the resident had impaired cognition and impaired decision making. R5's "Negotiated Service Agreement" (NSA) dated 04/02/22 identified "staff' would assist resident with activities of daily living. R5's medical record revealed he started on Hospice services on 05/20/22 related to decline in condition. His record did not include a revision of the NSA to identify he had a significant change in status and began Hospice services. On 12/28/22 at 11:19 AM "Licensed Nurse" B acknowledged she did not complete a revision to	S5116		

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S5116	Continued From page 6 the NSA for starting Hospice Services. The operator failed to ensure the review and if necessary, the revision of each negotiated service agreement for R5 following any significant change in condition, as defined in KAR 26-39-100.	S5116		
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 12 residents. The sample included three residents. Based on observation, interview, and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of three (R3, R4, R5) of three sampled residents in accordance with their "Functional Capacity Screen" and their "Negotiated Service Agreement". Findings included:	S5155		

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- Review of R3's medical record revealed she moved into the facility on 07/23/21with diagnoses of diabetes mellitus type II and blindness.

R3's "Functional Capacity Screen" (FCS) dated 01/25/22 revealed the resident required physical assistance with bathing, dressing and toileting, was unable to manage her medications and medical treatments. It also identified she had bladder incontinence and impaired vision.

R3's "Negotiated Service Agreement" (NSA) dated 01/25/22 failed to include services related to impaired vision. The NSA identified the "staff" would assist resident with bathing, dressing, and toileting and "staff" would perform medication management and monitor glucose monitoring seven days a week. The NSA failed to identify the "Certified Medication Aide" (CMA) dialed the resident's insulin pen and the resident self-injected her insulin.

R3's "Health Care Service Plan" failed to include services related to blindness, such as cueing and other interventions to help the resident be as independent as possible. It identified the resident at high risk for falls related to blindness but failed to include services to help reduce the risk for falls.

Observation on 12/27/22 at 01:45 PM CMA D pushed resident to her room and directly in front of her recliner. CMA D told the resident exactly where she was in proportion to the chair. R3 reached out to touch the arm of the chair and then stood without assistance and turned and sat in the chair. Staff then handed her the cordless

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phone and the TV remote prior to leaving the room.

On 12/27/22 at 04:24 PM R3 reported that she was blind and could not see anything. She stated staff helped her as needed and they will tell her where different foods are on her plate, set her meals up the same, have her supplies in the room set up the same and let her know if anything has changed.

On 12/28/22 at 09:58 AM "Certified Nurse Aide" (CNA) F reported staff had to make sure things were set up for her since she was blind. Staff make sure she has access to pads and other personal items, will keep drawers partially open for her to feel and get what she needs. We take her to and from meals in the wheelchair and the dietary staff will cue her as to where things are when they bring out her plate. She takes herself to the bathroom and she can get her pads out of the drawer.

On 12/28/22 at 11:09 AM "Administrative Licensed Nurse" B acknowledged the interventions for the resident's blindness as well as the resident self-injecting insulin was not included on the health care service plan.

The operator failed to ensure designated staff developed R3's Health Care Service Plan according to the FCS and the NSA.

- Review of R4's medical record revealed she moved into the facility on 11/06/21 with diagnoses of multiple sclerosis, diabetes mellitus, and had a history of pressure ulcers.

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S5155	Continued From page 9 R4's "Functional Capacity Screen" (FCS) dated 01/25/22 identified the resident was unable to perform all activities of daily living (ADL) except she was independent with eating and was unable to manage her medications or medical treatments. It also noted the resident used a mechanical lift and to "see MAR" (Medication Administration Record) for ordered treatments. R4's "Negotiated Service Agreement" dated 01/25/22 identified "staff" performed bathing, dressing, toileting, transfers and mobility for resident and "staff" performed management of medications seven days per week and performed wound care as needed. R4's "Health Care Service Plan" dated 01/26/22 failed to include health care services related to the resident use of a mechanical lift, that it took 2 staff for transfers and health care services to promote healing of pressure wounds. Observation on 12/28/22 at 01:42 PM with "Certified Medication Aide" E while providing pressure wound dressing changes revealed the resident had multiple open areas on both buttocks that were superficial in depth. She also had areas on her right and left ischium that were in the healing process. On 12/28/22 at 08:30 AM the resident reported she has had problems with pressure sores for the past 26 years. She stated the staff reposition her every two hours and she is up in her chair for a couple hours during supper. She stated she used the bed rails to help to roll from side to side with staff assistance.	S5155		

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S5155	Continued From page 10 On 12/28/22 at 09:54 AM "Certified Nurse Aide" F reported staff transfer her out of bed using the mechanical lift into her motorized scooter. We have to reposition her every two hours from side to side and keep pillows in place under her legs and her head. On 12/28/22 at 11:32 AM "Administrative Licensed Nurse" B acknowledged the health care service plan should have included the use of 2 staff for transfers with the mechanical lift, the motorized scooter, and interventions for pressure sores such as repositioning and the low air loss mattress. The operator failed to ensure designated staff developed R4's Health Care Service Plan according to the FCS and the NSA - Review of R5's medical record revealed he moved into the facility on 04/02/22 with diagnoses of hypertension, heart failure and dementia. R5's "Functional Capacity Screen" (FCS) dated 04/02/22 revealed the resident needed physical assistance with all activities of daily living except for eating and needed physical assistance with medications and medical treatments. It also identified the resident had impaired cognition and impaired decision making and was at risk for falls. . R5's "Negotiated Service Agreement" dated 04/02/22 failed to include services related to medical treatments, impaired cognition and impaired decision making. It identified "staff"	S5155		

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assisted with bathing, dressing, toileting, transfers and mobility for resident and "Staff" perform management of medications seven days per week.

R5's "Health Care Service Plan" dated 04/02/22 failed to include health care services related to the resident having sores on his toes and wound treatments, failed to include services related to impaired cognition and failed to include interventions related to the reduction of fall risk.

Observation on 12/27/22 at 01:55 PM "Certified Medication Aide" (CMA) G had taken the resident to his room from the dinner table via wheelchair. She put a gait belt on him, explained procedure and then CMA G and CMA D each got ahold of the gait belt and helped the resident to pivot transfer from his wheelchair to his recliner. CMA D took the tab alarm off the wheelchair and put it on the recliner and to resident's shirt.

On 12/28/22 at 10:05AM "Certified Nurse Aide" F acknowledged R5 was at risk for falls. Staff use 2 people for all transfers and walking, use a gait belt, he has a chair alarm on his recliner, tab alarm in the wheelchair and an alarm on his bed. He also has a floor mat we put beside the bed at night.

On 12/28/22 at 11:22 AM "Administrative Licensed Nurse" B acknowledged the "Health Care Service Plan" did not include any services related to the resident's risk for falls or his impaired cognition.

The operator failed to ensure designated staff developed R4's Health Care Service Plan

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S5155	Continued From page 12 according to the FCS and the NSA.	S5155		
S5165 SS=E	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 12 residents. The sample included three residents. Based on record review and interview for two R3, R4, of three sampled residents who had wound care treatments, the operator failed to provide documentation that a licensed nurse delegated nursing procedures not included in the medication aide curriculums to certified staff members performing wound care dressing changes according to the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included: - Review of R3's medical record revealed she moved into the facility on 07/23/21 with diagnoses of diabetes, mellitus type II and blindness. R3's "Functional Capacity Screen" dated 01/25/22 revealed she could not manage her medications or medical treatments.	S5165		

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S5165	Continued From page 13 R3's "Negotiated Service Agreement" and her "Health Care Service Plan" dated 01/25/22 identified "staff performed medication administration and glucose monitoring seven days per week". It did not identify that the resident also received wound care treatments. R3's record also included a medical provider's order dated 11/28/22 to treat wound on left shin with Medihoney patch, non-adherent gauze and wrap with gauze and secure with paper tape. R3's December 2022 "Medication Administration Record" included the following: "Treatment L shin Medihoney, cover with Adaptic (a type of wound dressing) and secure with kerlix". It is signed of by "Certified Medication Aide" (CMA) initials as evidence the CMAs were changing the wound dressing to her left shin. On 12/28/22 at 10:29 AM "Administrative Staff" A looked through CMA D and CMA E's employee files and acknowledged they had not had nurse delegation of changing the type of dressing for R3's legs. On 12/28/22 at 11:59 AM "Licensed Nurse" B reported she had not completed delegation or competency checks for the medication aides regarding wound care and specific dressing changes. The operator failed to ensure certified medication aides were properly trained on the specific procedure for wound dressing changes for R3. - Review of R4's medical record revealed she	S5165		

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moved into the facility on 11/06/21 with diagnoses of multiple sclerosis, diabetes mellitus, and history of pressure ulcers.

R4's "Functional Capacity Screen" dated 01/25/22 identified the resident was unable to manage her medications or medical treatments.

R4's "Negotiated Service Agreement" dated 01/25/22 identified staff performed wound care as needed.

R4's "Health Care Service Plan" identified the service of wound dressing change every 3 days and as needed.

R4 had current physician's orders dated 12/05/22 for the following wound dressing changes:

1 - Right ischial - cleanse wound with normal saline, alternate Clobetasol and Triad wound dressings , use ABD for absorption - cut Alginate (type of wound dressing) to shape of wound bed, Cutimed Sobact (a type of wound dressing) cut to shape of wound apply to wound bed. Place Sorbact first and then alginate, secure with paper tape.

2-Perineum wound - cleanse with normal Saline, alternate Clobetasol and Triad wound dressings, place interdry between thighs and on perineum secure with paper tape -

3-Left Ischial - cleanse wound with normal saline, alternate topical Clobetasol and Triad wound dressing, ABD (abdominal) pad for absorption. Cut Alginate to shape of wound bed, cut Cutimed

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Sobact to shape of wound, then apply Sorbact first and then Alginate and secure dressing with paper tape.

R4's December 2022 "Medication Administration Record" included the following:

Wound treatment for right and left ischial- Remove old dressing carefully, clean wound with wound cleaner and alternate clobetasol and Triad cream, place Sobact first and then alginate, cut alginate and Sobact to shape of wound. Use ABD (absorbent dressing) for absorption and secure with paper tape, change dressing daily and as needed for saturation, dislodgement or if soiled.
Wound treatment for Perineum- remove old dressing carefully, clean wound with wound cleaner. Alternate clobetasol and triad cream place interdry between thighs and on perineum.

Both treatments are signed of by "Certified Medication Aide" (CMA) initials as evidence the CMAs were changing the wound dressings to her buttocks/ischial region and her perineum.

On 12/28/22 at 10:29 AM "Administrative Staff" A looked through CMA D and CMA E's employee files and acknowledged they had not had nurse delegation of changing the type of dressing for R4.

On 12/28/22 at 11:59 AM "Licensed Nurse" B reported she had not completed delegation or competency checks for the medication aides regarding wound care and specific dressing changes.

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S5165	Continued From page 16 On 12/28/22 at 02:22 PM CMA E reported she had not had any training from a licensed nurse on how to properly do the wound care dressings for R4. The operator failed to ensure certified medication aides were properly trained on the specific procedure for wound dressing changes for R4.	S5165		
S5225 SS=E	26-42-207 (a) (b) (1)(2)(3)(4) Infection Control a) The administrator or operator of each home plus 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; This REQUIREMENT is not met as evidenced by: KAR 26-42-207(b)(2) The facility reported a census of 12 residents (R). The sample included three. Based on observation, interview, and record review the operator failed to ensure staff implemented	S5225		

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procedures to prevent the spread of infections by failing to follow single-use glove guidelines for dressing changes for two (R3 and R4) of three sampled residents.

Findings included:

Review of R3's medical record revealed she moved into the facility on 07/23/21with diagnoses of diabetes mellitus type II and blindness.

R3's "Functional Capacity Screen" (FCS) dated 01/25/22 revealed the resident required physical assistance with bathing, dressing and toileting, was unable to manage her medications and medical treatments. It also identified she had bladder incontinence and impaired vision.

R3's "Negotiated Service Agreement" (NSA) dated 01/25/22 and the "Health Care Service Plan" dated 01/26/22 did not identify services related to wound care.

Review of the physician's order dated 11/28/22 directed staff to treat wound with Medihoney patch, non adherent gauze, and kerlix secured with paper tape.

Observation on 12/28/22 at 11:31 AM "Certified Medication Aide" (CMA) E went into resident's room to change the dressing to her left shin. CMA E put on two pairs of gloves, unwrapped the kerlix and removed the dressing. The dressing had dried blood on it and CMA E picked the Medihoney patches off the wounds with her right hand. With the same gloved hands CMA E squirted Normal Saline on a 4x4 gauze pad and then blotted the wound and surrounding skin.

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CMA E then removed the top pair of gloves and then cut the new Medihoney and placed a piece on each open wound area, covered them with nonstick gauze and then wrapped with kerlix. Staff removed her gloves and then secured the kerlix with paper tape.

Review of CMA E's employee file lacked evidence of delegation and competency testing for completion of this type of wound dressing.

On 12/28/22 at 02:26 PM "Administrative Licensed Nurse" B stated she would expect staff to change their gloves after removing the initial dressing, put on clean gloves and cleanse the wound site, remove gloves again and put on new ones to apply the new, clean dressing.

According to the "Centers for Disease Control and Prevention" hand hygiene and glove usage guidelines reveal if performing a task that requires gloves, hand hygiene should be performed prior to putting on the gloves and immediately after removing gloves. Gloves should be changed, and hand hygiene performed during resident care if moving from work on a soiled body site to a clean body site on the same patient.

The operator failed to ensure proper hand hygiene and glove usage was used during wound care and dressing change for R3.

- Review of R4's medical record revealed she moved into the facility on 11/06/21with diagnoses of multiple sclerosis, and diabetes mellitus, and history of pressure ulcers.

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S5225	Continued From page 19 R4's "Functional Capacity Screen" (FCS) dated 01/25/22 identified the resident was unable to perform all activities of daily living (ADL) except she was independent with eating and was unable to manage her medications or medical treatments. It also noted the resident used a mechanical lift and to "see MAR" (Medication Administration Record) for ordered treatments. R4's "Negotiated Service Agreement" dated-1/25/22 identified "staff" performed bathing, dressing, toileting, transfers and mobility for resident and "Staff" perform management of medications seven days per week and performed wound care as needed. Observation 12/28/22 at 01:42 PM "Certified Medication Aide" (CMA) E went into resident room to prepare to change the resident's dressings on her wounds. After positioning the resident with assistance of "Certified Nurse Aide" F, CMA E put on 2 pairs of gloves and opened multiple packages of 4x4 gauze pads. CMA E sprayed R4's perineum with wound cleanser and wiped area with 4x4 each side and down the middle. Each time the gauze dressing had bloody drainage when wiped. With the same gloves on she then pulled on the turn pad and rolled the resident onto her left side. She removed absorbent dressings which revealed strips of green dressings on both side of her buttocks approximately 2" by 4 ". CMA E stated the green dressing was the Sorbact and the whit was the Alginate (both a type of wound dressing). CMA E sprayed the resident's buttock to moisten dressing to aide in removal. She then removed the dressing on R4's	S5225		

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right buttock and proceeded to remove all the dressing. The dressing was taped to the resident's left hip in a way that she was not able to fully remove the dressing, so she rolled it together and tucked it under R4's hip. She then sprayed the resident's bottom with wound cleanser and with the same gloves used to remove the dressing, proceeded to blot, and wipe clean multiple areas on the resident's bottom.
Observation revealed two main areas, one on each buttock that was superficially open as well as multiple areas with fresh bleeding. The open areas ranged from pinpoint to 2 inches in diameter. CMA E then removed her top layer of gloves and then applied Clobetasol cream onto her fingers and then applied to all open areas on the resident's right buttock and ischium area. CMA E then covered an area on R4's right buttock with Sorbact (green dressing)and then with the white Alginate. With the same pair of gloves, CMA E then applied the Clobetasol cream to all open areas on the resident's left hip and covered them with the Sorbact and Alginate. CMA E then applied absorbent dressings to cover the areas and secured with tape and removed her gloves. CMA E put a clean chux under the resident's hip and then they rolled the resident onto her back. CNA F and CMA E then rolled the resident onto her right side to finish the dressing change. CMA E put on clean gloves and pulled out the initial dressing, arranged the new Sorbact dressing after repositioning the resident and covered with another absorbent dressing and secured with tape.

CMA E failed to perform hand hygiene between changing gloves and did not change gloves after

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S5225	Continued From page 21 touching the initial soiled dressing. On 12/28/22 at 02:26 PM "Administrative Licensed Nurse" B stated she would expect staff to change their gloves after removing the initial dressing, put on clean gloves and cleanse the wound site, remove gloves again and put on new ones to apply the new, clean dressing. According to the "Centers for Disease Control and Prevention" hand hygiene and glove usage guidelines reveal if performing a task that requires gloves, hand hygiene should be performed prior to putting on the gloves and immediately after removing gloves. Gloves should be changed, and hand hygiene performed during resident care if moving from work on a soiled body site to a clean body site on the same patient. The operator failed to ensure proper hand hygiene and glove usage was used during wound care and dressing change for R4.	S5225		
S5230 SS=E	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s	S5230		

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S5230	Continued From page 22 tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: K.A.R 26-42-207(c) The facility reported a census of 12 residents (R). The sample included three residents. Based on interview and record review for two (R3, R4) of three sampled residents and one of five newly hired employees, the operator failed to ensure the facility remained in compliance with the department's tuberculosis(TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This failure had the potential to affect all residents in the assisted living facility. Findings included: - Review of R3's medical record revealed she moved into the facility on 07/23/21and her record included a TB symptom screen and one TB skin test conducted at a different facility. The record failed to include a second TB skin test. - Review of R4's medical record revealed she moved into the facility on 11/06/21 and did not receive a two-step TB skin test. On 12/28/22 at 11:06 AM "Licensed Nurse" B stated residents were supposed to get a two-step skin test and symptom screen completed within seven days of admission. She acknowledged R3 and R4 did not have the two-step skin testing	S5230		

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S5230	Continued From page 23 completed. For R3 and R4, the operator failed to ensure residents received a TB two-step skin test within seven days of admission. - Review of 5 newly hired employees files on 12/27/22 revealed the following: Dietary staff C hired on 10/28/21 did not have evidence of getting a two-step TB skin test within seven days of employment. On 12/27/22 at 01:36 PM Administrative Staff A acknowledged dietary staff C did not have a two-step skin test completed. The operator failed to ensure one of five newly hired employees had TB two-step skin test completed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S5230		
S5251 SS=E	26-42-105 (f) (11) Resident Records 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 26-42-105(f)(11)	S5251		

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The facility reported a census of 12 residents (R). The sample included three residents. Based on interview and record review the operator failed to ensure the record contained documentation of all incidents, symptoms, and other indications of illness or injury, including the action taken, and results of the action for three (R3, R4, R5) of three sampled residents who had skin tears and/or wounds.

Findings included:

- Review of R3's medical record revealed she moved into the facility on 07/23/21with diagnoses of diabetes mellitus type II and blindness.

R3's "Functional Capacity Screen" (FCS) dated 01/25/22 revealed the resident required physical assistance with bathing, dressing and toileting, was unable to manage her medications and medical treatments. It also identified she had bladder incontinence and impaired vision.

R3's "Negotiated Service Agreement" (NSA) dated 01/25/22identified the "staff" would assist resident with bathing, dressing, and toileting and "staff" would perform medication management and monitor glucose monitoring seven days a week.

Review of the resident's nursing progress notes revealed the following:
10/14/21 - wounds on bottom cleaned - Medihoney cream applies to area. The next documentation on the status of the residents wound was on 12/03/21 when it healed.
12/03/21 (no time) - L great toe swollen and bruised, resident denies pain and can move toe

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without difficulty.
12/04/21 - states shoes make her L great toe hurt.
12/04/21 - L great toe remains swollen and very bruised - states it hurts to have shoes on - will continue to monitor.
The record lacked follow up regarding the resident's swollen toe and if anything was done regarding her shoes.
02/18/22 - skin tear to LLL 1.5 x 0.25 - physician faxed - The record lacked follow-up on her skin tear.
03/24/22 - skin tear to R shin - xeroform - The record lacked follow up regarding skin tear to right shin.
04/21/22 - c/o tenderness to buttock - 5mm open area to fold of R buttock - Medihoney to area.
The record lacked follow-up as to treatment and progression of open area on buttock.
11/14/22 - open area to L shin 2.5 cm X 2 cm - no foul odor - wound bed barely red - Medihoney applied - physician aware -

The resident's record lacked evidence of a Licensed Nurse follow-up regarding multiple skin tears/wounds to include the treatment provided and the effectiveness of that treatment.

On 12/28/22 at 11:13 AM "Administrative Licensed Nurse" B acknowledge that she did not routinely document on skin tears or wound and did not include treatment or follow-up on concerns identified in the nurse's notes.

The operator failed to ensure the resident's record included documentation of a Licensed Nurse followed-up regarding treatment done, results of the treatment related to skin tears,

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S5251	Continued From page 26 wounds, and swelling of R3's L great toe. - Review of R4's medical record revealed she moved into the facility on 11/06/21with diagnoses of multiple sclerosis, and diabetes mellitus, and history of pressure ulcers. R4's "Functional Capacity Screen" (FCS) dated 01/25/22 identified the resident was unable to perform all activities of daily living (ADL) except she was independent with eating and was unable to manage her medications or medical treatments. R4's "Negotiated Service Agreement" dated 01/25/22 identified "staff" performed bathing, dressing, toileting, transfers and mobility for resident and "Staff" perform management of medications seven days per week and performed wound care as needed. Review of the resident's nursing progress notes revealed the following: 02/99/22 -The resident left for wound care. The record lacked follow-up on the residents return and treatment done at wound care clinic. 03/18/22 - Faxed physician regarding wound to lateral side of right 3rd toe. The record lacked follow-up on treatment for her toe and results of treatment. 06/08/22 - Resident admitted to hospital for sepsis (a systemic reaction which causes inflammation throughout the entire body) - The record lacked documentation of the resident returning from the hospital and status upon return. 08/11/22 - Dressing changed to right and left ischium and perineum. Cleansed wound,	S5251		

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Cutimed Sobact applied to R ischium and Silver alginate applied to L ischial wound.

The resident's record lacked evidence of a licensed nurse routinely assessing the resident's wounds including measurements, description of the wound bed and results of treatment.

On 12/28/22 at 11:30 AM, "Administrative Licensed Nurse" B acknowledges she had not routinely documented the status of R4's wounds including measurements and description of the wounds.

The operator failed to ensure R4's record contained documentation of all wounds and follow up on treatments and results of treatments.

- Review of R5's medical record revealed he moved into the facility on 04/02/22 with diagnoses of hypertension, heart failure and dementia.

R5's "Functional Capacity Screen" (FCS) dated 04/02/22 revealed the resident needed physical assistance with all activities of daily living except for eating and needed physical assistance with medications and medical treatments. It also identified the resident had impaired cognition and impaired decision making.

R5's "Negotiated Service Agreement" dated 04/02/22 failed to include services related to medical treatments, impaired cognition and impaired decision making. It identified "staff" assisted with bathing, dressing, toileting, transfers and mobility for resident and "Staff"

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perform management of medications seven days per week.

Review of R5's nursing progress notes included the following:
04/02/22 - wound to Left great toe and right second toe - documentation lacked description of the wound and treatment provided.
05/21/22 - noted Right 2nd toes open wound. The documentation lacked description of the wound and treatment provided.
06/16/22 - dressing changed to Left great toe - cleansed with wound wash then applied Santyl ointment and covered with Band-Aid. wounds to Right 3rd and 4th toe cleansed and covered with Band-Aids -
110/3/22 - 2300 - received call earlier in shift about resident havening emesis with rest periods between episodes of nausea. Scant amount of emesis at this time, mostly dry heaving and resident alert when spoken to. The record lacked follow-up to the resident having nausea/emesis and what treatment was provided.
12/08/22 - assessed new wound to right great toe and right second toe on medial side - 5 millimeters in size with purulent drainage.
12/17/22 - dressing right second toe changed with no drainage noted.

The record lacked evidence of a Licensed Nurse routinely assessing wounds on resident's toes including documentation of the sizes of wounds, description of the wound, treatment provided and results of the treatment.

On 12/28/22 at 11:25 AM "Administrative Licensed Nurse" B acknowledged she did not routinely assess and document findings of the

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	B076002	A. BUILDING: _____ B. WING _____	12/28/2022

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S5251	Continued From page 29 assessment of the resident's wounds or other identified symptoms of illness such as emesis. The operator failed to ensure the resident's record included documentation of all incidents, symptoms, and indications of illness or injury including the action taken and the results of the action.	S5251		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home 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 home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d) The facility reported a census of 12 residents (R). The sample included three residents. Based on interview and record review the operator	S5300		

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S5300	Continued From page 30	S5300		

failed to ensure that one (R4) of three sampled residents whom the facility was responsible for the administration of their medications, received their medications and biologicals in accordance with a medical care provider's written order and professional standards of practice.

Findings included:

- Review of R4's medical record revealed she moved into the facility on 11/06/21with diagnoses of multiple sclerosis, and diabetes mellitus, and history of pressure ulcers.

R4's "Functional Capacity Screen" (FCS) dated 01/25/22 identified the resident was unable to perform all activities of daily living (ADL) except she was independent with eating and was unable to manage her medications or medical treatments. It also noted the resident used a mechanical lift and to "see MAR" (Medication Administration Record) for ordered treatments.

R4's "Negotiated Service Agreement" dated 01/25/22 identified "staff" performed bathing, dressing, toileting, transfers and mobility for resident and "Staff" perform management of medications seven days per week and performed wound care as needed.

R4's record included the following physician orders dated 12/05/22 for wound care dressing: #1 - R ischial wound: cleanse wound with normal saline, alternate Clobetasol cream and Triad cream wound dressings, use ABD (abdominal dressing) for absorption. Cut Alginate to shape of wound bed, Cutimed Sobact cut to shape of wound apply to wound bed. Place

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Sorbact first and then Alginate and secure with paper tape
#2-Perineum wound: Cleanse with normal Saline, alternate Clobetasol cream and Triad cream wound dressings, place interdry (absorbent dressing) between thighs and on perineum and secure with paper tape -
#3-Left Ischial: Cleanse wound with normal saline, alternate topical Clobetasol and Triad wound dressing, apply ABD for absorption. Cut alginate and Cutimed Sobact to shape of wound, apply Sorbact first and then Alginate and secure with paper tape.

Review of the December 2022 "Medication Administration Record" (MAR) included in one entry the administration of the two creams that were to be alternated each dressing change. It read: "Wound treatment for right ischial and left ischial, removed old dressing carefully, clean wound with wound cleaner and alternate Clobetasol and Triad cream..."

On 12/28/22 at 01:39 PM CMA E acknowledged the MAR does not differentiate which day for what cream needed to be applied. She stated the only way to tell what cream to apply was one cream was pasty white and the other was clear.

On 12/28/22 at 02:26 PM "Administrative Licensed Nurse" B acknowledged the MAR did not identify what cream to apply on what days to ensure the treatments were administered according to physician's orders.

The operator failed to ensure the MAR entries were entered in a way to ensure alternating wound creams were administered according to

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S5300	Continued From page 32 physician's orders.	S5300		
S5315 SS=E	26-42-205 (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 home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home 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 home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.	S5315		

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S5315	Continued From page 33 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h)(4) The facility reported a census of 12 residents. Based on observation, interview, and record review the Operator failed to ensure staff stored medications in accordance with manufacturer's recommendations to ensure medications were not accidentally administered beyond the manufacturers or pharmacy recommended date of expiration. Findings included: - On 12/27/22 at 12:09 PM "Certified Medication Aide" D unlocked the medication room for inspection. Observation revealed a small plastic basked on the counter with two insulin pens in it. The Basaglar pen had an open date of 12/25/22 but the Novolog pen had 180 unites left in it and did not include a date when it was initially put into use. CMA D stated she did not know when it was first used. In the refrigerator was a vial of Tubersol that had the cap removed and was about 3/4 full. Neither the box nor the vial had a date that it was initially used. On 12/28/22 at 02:12 PM "Administrative Licensed Nurse" B acknowledged the insulin pens and Tubersol solution did not have the date on the pen and box/vial when staff first used it. Per Manufacture's recommendations, the NovoLog FlexPen package insert revealed the	S5315		

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S5315	Continued From page 34 pen currently being used should be thrown away after 28 days, even if it still has insulin left in it. Per Manufacturers recommendations, a vial of Tubersol which has been entered and in use for 30 days should be discarded. The operator failed to ensure designated staff dated insulin pens and Tubersol solution, to ensure they were not accidentally administered beyond the manufacturers recommended date of expiration.	S5315		