STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089098	A. BUILDING: _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL HOME LLC	3100 SE ILLINOIS AVE TOPEKA, KS 66605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints #175864, #174551, #166755, #166328, and #166314, at the above named home plus facility conducted on 03/23/23, 03/27/23, and 03/28/23.	S 000		
S5029 SS=F	26-42-101 (g) Availability of policies and procedures (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(g) The facility reported a census of seven residents. Based on observation and interview the operator failed to ensure a notice of the availability of the facility's policies and procedures was posted in a place accessible to all residents. Findings included: - Observation on 03/23/23 at approximately 09:34 AM during the initial tour revealed a notice that the facility's policies and procedures were available was not posted. On 03/28/23 at approximately 12:05 PM	S5029		

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

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S5029	Continued From page 1 Administrative Staff A confirmed a notice of the facility's policies and procedures available was not posted. The operator failed to ensure a notice of the availability of the facility's policies and procedures was posted in a place accessible to all residents.	S5029		
S5050 SS=F	26-42-101 (k) Ombudsman (k) Ombudsman. Each administrator or operator shall ensure the posting of the names, addresses, and telephone numbers of the Kansas department on aging and the office of the long-term care ombudsman with information that these agencies can be contacted to report actual or potential abuse, neglect, or exploitation of residents or to register complaints concerning the operation of the home. The administrator or operator shall ensure that this information is posted in a common area accessible to all residents and the public. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(k) The facility reported a census of seven residents. Based on observation and interview the operator failed to ensure the ombudsman and the department's names, addresses, and telephone numbers were posted in a common area accessible to all residents and the public. Findings included:	S5050		

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S5050	Continued From page 2 - Observation on 03/23/23 at approximately 09:34 AM during the initial tour revealed the ombudsman and the department's names, addresses, and telephone numbers were not posted in a common area. On 03/23/23 at 11:44 AM Certified Medication Aide (CMA) B confirmed the ombudsman and the department's names, addresses, and telephone numbers were not posted in a common area. The operator failed to ensure the ombudsman and the department's names, addresses, and telephone numbers were posted in a common area accessible to all residents and the public.	S5050		
S5095 SS=D	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(d) The facility reported a census of seven residents with three residents included in the sample and two closed record reviews. Based on observation, interview, and record review the operator failed to ensure the "Functional Capacity Screen" (FCS) for Resident (R) 323 accurately reflected his functional capacity at the	S5095		

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S5095	Continued From page 3	S5095		

time of screening.

Findings included:

- Review of R323's record revealed an admission date of 08/17/22 with the following diagnoses: end-stage kidney failure, cognitive impairment, and diabetes mellitus.

The 10/11/22 "Functional Capacity Screen" identified R323 was unable to perform bathing, dressing, toileting, transfers, and management of medications and treatments; required physical assistance with walking/mobility and eating; was incontinent of bladder; had short-term and long-term memory loss, and memory/recall and decision-making cognitive impairments; was sometimes understandable and sometimes understood others during communication; and was marked for falls, impaired decision-making, wandering, and inappropriate behavior.

R323 was not marked for impaired vision on the "FCS"

The 10/11/23 "NSA" for R323 identified facility staff would provide total care/assistance for bathing, dressing, toileting, walking/mobility, and eating; management of medications and treatments; he wore briefs for bladder incontinence; and facility staff would provide management of inappropriate behavior. Transfers, cognition, communication, falls, impaired decision-making, and wandering were not addressed on the "NSA."

Observation on 03/23/23 at 12:30 PM revealed R323 ambulated from bathroom to the common

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S5095	Continued From page 4 area with Certified Medication Aide (CMA) B's assistance. He walked behind CMA B with his hands on her shoulders. CMA B provided verbal instructions to "pivot", "back up," and "sit." On 03/23/23 at 01:49 PM Certified Medication Aide (CMA) B stated R323 was blind. On 03/27/23 at 11:29 AM Administrative Staff A confirmed R323 was blind and impaired vision was not marked on his "FCS." On 03/27/23 at 04:47 the facility's "FCS" policy was requested which was not provided by the end of the survey. The operator failed to ensure the "FCS" for R323 accurately reflected his functional capacity at the time of screening.	S5095		
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	S5105		

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S5105	Continued From page 5 payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)(2)(3) The facility reported a census of seven residents with three included in the sample and three closed record reviews. Based on interview and record review the operator failed to ensure the development of a written "Negotiated Service Agreement" (NSA) for Resident (R) 323, R324, R325, and R328 based on their "Functional Capacity Screen" (FCS), failed to identify the party responsible for payment for hospice for R323, and failed to identify the outside provider for home health and party responsible for payment for home health for R325. Findings included: - Review of R323's record revealed an admission date of 08/17/22 with the following diagnoses: end-stage kidney failure, cognitive impairment, and diabetes mellitus. The 10/11/22 "FCS identified R323 was unable to perform transfers; had short-term and long-term memory loss, and memory/recall and decision-making cognitive impairments; was sometimes understandable and sometimes understood others during communication; and was marked for falls, impaired decision-making, and wandering. The 10/11/23 "NSA" for R323 failed to identify the services facility staff would provide for	S5105		

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S5105	Continued From page 6	S5105		

transfers, cognitive impairments, communication difficulties, to prevent falls, and manage impaired decision-making and wandering. His "NSA" also failed to identify the party responsible for payment for hospice.

- Review of R324's record revealed an admission date of 05/25/22 with the following diagnoses: dementia with behaviors and anxiety.

The 05/25/22 "FCS" identified R324 had short-term and long-term memory loss, and memory/recall and decision-making cognitive impairments; and was sometimes understandable and rarely or never understood others during communication.

The 05/25/22 "NSA" for R324 failed to identify the services facility staff would provide for cognitive impairments and communication difficulties.

- Review of R325's record revealed an admission date of 02/01/23 with the following diagnoses: traumatic brain injury and seizures.

The 02/01/23 "FCS" identified R325 required physical assistance with transfers; had short-term and long-term memory loss, and memory/recall and decision-making cognitive impairments; was sometimes understandable and sometimes understood others during communication; and was marked for falls, impaired decision-making, wandering, and inappropriate behavior.

The 02/01/23 "NSA" for R325 failed to identify the services facility staff would provide for

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S5105	Continued From page 7	S5105		

transfers, cognitive impairments, communication difficulties, to prevent falls, and manage impaired decision-making, wandering, and inappropriate behavior. His "NSA" also failed to identify the home health provider and the party responsible for payment for home health services.

- Review of R328's record revealed an admission date of 08/13/21 with a diagnosis of schizophrenia.
The 08/13/21 "FCS" identified R328 required physical assistance for transfers and management of medications; was occasionally incontinent of bladder; had short-term and long-term memory loss, and memory/recall and decision-making cognitive impairments; was sometimes understandable and rarely or never understood others during communication; and was marked for falls, impaired hearing, impaired decision-making, and wandering.

The 08/13/21 "NSA" failed to identify the services facility staff would provide for transfers, management of medication, bladder incontinence, cognitive impairments, communication difficulties, to prevent falls, and manage impaired hearing, impaired decision-making, and wandering.

On 03/27/23 at 11:50 AM Administrative Staff A confirmed transfers, cognition, communication, falls, impaired decision-making, wandering, and the party responsible for payment for hospice were not addressed on R323's "NSA."

On 03/27/23 at 02:13 PM Licensed Nurse C confirmed cognitive impairments and communication difficulties were not addressed on

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S5105	Continued From page 8 R324's "NSA." On 03/27/23 at 02:04 PM Administrative Staff A confirmed cognition, communication, impaired decision-making, wandering, and inappropriate behavior were not addressed on R325's "NSA" and the "NSA" failed to identify the outside providers and party responsible for payment for home health. On 03/27/23 at 04:47 the facility's "NSA" policy was requested which was not provided by the end of the survey. The operator failed to ensure the development of a written "NSA" for R323, R324, R325, and R328 based on their "Functional Capacity Screen" (FCS), failed to identify the party responsible for payment for hospice for R323, and failed to identify the outside provider for home health and party responsible for payment for home health for R325.	S5105		
S5161 SS=E	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 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 five residents with three included in the sample. Based on	S5161		

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S5161	Continued From page 9	S5161		

interview and record review the operator failed to ensure Resident (R) 323's and R324's "Negotiated Service Agreements" (NSA) named the licensed nurse responsible for implementing and supervising their "Healthcare Service Plans" (HSP).

Findings included:

- Review of R323's record revealed an admission date of 08/17/22 with the following diagnoses: end-stage kidney failure, cognitive impairment, and diabetes mellitus.

The 10/11/22 "Functional Capacity Screen" identified R323 was unable to perform bathing, dressing, toileting, transfers, and management of medications and treatments; required physical assistance with walking/mobility and eating; was incontinent of bladder; had short-term and long-term memory loss, and memory/recall and decision-making cognitive impairments; was sometimes understandable and sometimes understood others during communication; and was marked for falls, impaired decision-making, wandering, and inappropriate behavior.

The 10/11/23 "NSA" for R323 identified facility staff would provide total care/assistance for bathing, dressing, toileting, walking/mobility, and eating; management of medications and treatments; he wore briefs for bladder incontinence; and facility staff would provide management of inappropriate behavior. Transfers, cognition, communication, falls, impaired decision-making, and wandering were not addressed on the "NSA."

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S5161	Continued From page 10	S5161		

R323's "NSA" failed to name the licensed nurse responsible for implementing and supervising the "HCP."

- Review of R324's record revealed an admission date of 05/25/22 with the following diagnoses: dementia with behaviors and anxiety.

The 05/25/22 "FCS" identified R324 was unable to perform bathing, dressing, and management of medications and treatments; she required physical assistance with toileting, and eating; she was sometimes incontinent of bladder; had short-term and long-term memory loss, and memory/recall and decision-making cognitive impairments; and was sometimes understandable and rarely or never understood others during communication.

The 05/25/22 "NSA" for R324 identified facility staff would provide assistance with bathing, toileting, and eating; cueing with dressing; management of medications and treatments; staff would assist with bladder incontinence and monitor environment for safety to prevent falls. Cognition and communication were not addressed on the "NSA."

R324's "NSA" failed to name the licensed nurse responsible for implementing and supervising the "HCP."

On 03/27/23 at 11:50 AM Administrative Staff A confirmed the nurse responsible was not named on the "NSAs."

The operator failed to ensure R323 and R324's "NSAs" named the licensed nurse responsible for

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S5161	Continued From page 11 implementing and supervising his "HSPs."	S5161		
S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(f) The facility reported a census of seven residents. The facility had a main kitchen where food was stored and prepared. Based on observation and interview the operator failed to ensure foods were stored under safe conditions. Findings included: - Observation on 03/23/23 at 09:36 AM revealed a refrigerator and freezer was in the facility's main kitchen which contained food items for the residents. A temperature log was present with temperatures documented for the months of January and up to 02/07/23 in February. After 02/07/23 until 03/23/23 at the start of the survey the temperature log was blank which was 44 days. Observation on 03/23/23 at 09:51 AM revealed a large upright freezer was in the facility's garage	S5195		

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S5195	Continued From page 12 which contained food items for the residents. A temperature log was not present. There was a pallet on the garage floor next to a shelf that contained food items. The pallet contained an opened case of water in disposable drinking bottles and two two-gallon plastic jugs of laundry detergent. On 03/23/23 at 09:55 AM Certified Medication Aide (CMA) B confirmed temperature logs lacked documentation of temperatures for the refrigerator and freezer in the main kitchen and the freezer in the garage. The August 2017 Kansas Department of Agriculture's "Focus on Food Safety" booklet documented cold foods must be maintained at an internal temperature of 41 degrees Fahrenheit (F) or below and poisonous or toxic items must be stored separately from foods and food contact surfaces. On 03/27/23 at 04:47 the facility's food storage policy was requested which was not provided by the end of the survey. The operator failed to ensure foods were stored under safe conditions.	S5195		
S5215 SS=F	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;	S5215		

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S5215	Continued From page 13 (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)(3) The facility reported a census of seven residents. Based on interview and record review the operator failed to provide quarterly reviews of the facility's emergency management plan with staff and residents. Findings included: - On 03/23/23 at approximately 10:25 AM the dates of the quarterly reviews of the facility's emergency management since the previous survey was requested. The facility failed to provide evidence of documentation quarterly reviews were conducted with residents and staff. On 03/28/23 at 11:52 AM Administrative Staff A confirmed she has not conducted any reviews of the facility's emergency management plan with staff and residents. The operator failed to provide quarterly reviews of the facility's emergency management	S5215		

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S5215	Continued From page 14 plan with employees and residents.	S5215		
S5230 SS=F	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 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(c) The facility reported a census of seven residents. Based on interview and record review 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 KAR 26-39-105 for Resident (R) 325 and R324 and three staff employed by the facility. Findings included: - Record review for R325 revealed an admission date of 02/01/23 with the following diagnoses:	S5230		

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S5230	Continued From page 15 traumatic brain injury, kidney mass, and seizures. Review of R325's TB skin tests and results revealed the second step test was administered on 02/10/23 and results were read on 02/14/23 which was not within 72 hours. - Record review for R324 revealed an admission date of 05/25/22 with the following diagnoses: dementia with behaviors and anxiety. Review of R324's TB skin tests and results revealed the first step test was administered on 06/27/22 which was 33 days after admission. - Record review for three employees working at the facility revealed the following: Licensed Nurse D's employee record revealed a hire date of 06/16/22. She was administered the first step TB skin test on 06/10/22 and a second step TB skin test on 06/12/22. The second test was administered two days after the first test. Certified Medication Aide (CMA) B's employee record revealed a hire date of 09/05/22. She was administered the first step TB skin test on 08/10/22 and a second step TB skin test on 08/15/22. The second test was administered 5 days after the first test and her record lacked evidence of documentation of TB skin test results for both step one and step two tests. Certified Nurse Aide (CNA) E's employee record revealed a hire date of 02/24/23. He was administered the first step TB skin test on 03/20/23 which was 24 days after hire.	S5230		

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S5230	Continued From page 16 On 03/28/23 at 01:57 PM Administrative Staff A confirmed R324's TB test was not administered within seven days of admission to the facility. On 03/28/23 at 02:33 PM Administrative Staff A confirmed R325's TB test result was not read within 72 hours. On 03/28/23 at 03:48 PM Administrative Staff A confirmed CMA E's TB test was not administered within seven days of hire. On 03/28/23 at 04:09 PM Licensed Nurse C confirmed Licensed Nurse D's second step TB test was administered two days after the first step and CMA B's record lacked evidence of documentation of TB skin test results for both step one and step two tests. The department's June 2013 "Tuberculosis (TB) Guideline for Adult Care Homes" documented "Each new resident and new employee shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of residency or employment. . .If the first step is read as not positive, a second TST shall be administered within 1 to 3 weeks. The second TST shall be read within 48-72 hours of its administration. . . Any test not read within 72 hours shall be repeated." On 03/27/23 at 04:47 the facility's TB policy was requested which was not provided by the end of the survey. The operator failed to ensure the facility remained in compliance with the department's	S5230		

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S5230	Continued From page 17 tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S5230		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(d)(1)(2) The facility reported a census of four residents. Based on interview and record review the operator failed to ensure evidence of licensure or certification was completed for all five sampled	S5258		

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S5258	Continued From page 18	S5258		

staff and criminal background checks were completed for four certified sampled staff upon hire.

Findings included:

- Record review for five employees revealed the following:

Licensed Nurse D's employee record revealed a hire date of 06/16/22. The employee record lacked evidence the registry was contacted to check licensure status.

Certified Medication Aide (CMA) B's employee record revealed a hire date of 09/05/22. The employee record lacked evidence the registry was contacted to check certification status and lacked evidence of supporting documentation a criminal background check was completed.

Certified Nurse Aide (CNA) E's employee record revealed a hire date of 02/24/23. The employee record lacked evidence the registry was contacted to check certification status and lacked evidence of supporting documentation a criminal background check was completed.

Certified Nurse Aide (CNA) F's employee record revealed a hire date of 08/01/22. The employee record lacked evidence the registry was contacted to check certification status and lacked evidence of supporting documentation a criminal background check was completed.

Certified Nurse Aide (CNA) G's employee record revealed a hire date of 02/25/23. The employee record lacked evidence the registry was

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S5258	Continued From page 19 contacted to check certification status and lacked evidence of supporting documentation a criminal background check was completed. On 03/28/23 at 03:34 PM Administrative Staff A confirmed staff records lacked evidence documentation that licensure or certification was completed for all five sampled staff and criminal background checks were completed for four certified sampled staff upon hire. On 03/27/23 at 04:47 the facility's staff records policy was requested which was not provided by the end of the survey. The operator failed to ensure evidence of licensure or certification was completed for all five sampled staff and criminal background checks were completed for four certified sampled staff upon hire.	S5258		
S5313 SS=F	26-42-205 (g) (3) Over the counter medication (g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container.	S5313		

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S5313	Continued From page 20 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(3) The facility reported a census of seven residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full names of the residents on the original packages of over-the-counter (OTC) medications. Findings included: - Observation on 03/28/23 at 10:45 AM revealed Certified Medication Aide (CMA) B unlocked and opened the medication cart where the medications for the residents were stored. The top drawer of the medication cart contained the following OTC medications were not labeled with resident's full names: One bottle of Tylenol 500 milligrams (mg), 200 gelcaps One bottle of acetaminophen 500 mg, 225 caplets One bottle of Flexmore homeopathic 50 quick dissolve tablets One tube of diphenhydramine itch relief salve in a box One box of biscodyl 5 mg, 10 tablets One box of diphenhydramine allergy 25 mg, 24 tablets One bottle of stool softener 100 mg, 400 softgels On 03/23/23 at approximately 10:45 AM CMA B confirmed the OTC medications were not labeled with residents' full names.	S5313		

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S5313	Continued From page 21 On 03/27/23 at 04:47 the facility's OTC medication policy was requested which was not provided by the end of the survey. The operator failed to ensure all OTC medications were labeled with the residents' full names.	S5313		
S5325 SS=D	26-42-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist or licensed nurse shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the home and each time the resident experiences any significant change in condition. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(l) The facility reported a census of seven residents with three residents included in the sample. Based on interview and record review the operator failed to ensure quarterly medication regimen reviews were conducted for Resident (R) 323 and R324. Findings included: - Review of R323's record revealed an admission date of 08/17/22 with the following	S5325		

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S5325	Continued From page 22	S5325		

diagnoses: end-stage kidney failure, cognitive impairment, and diabetes mellitus.

The 10/11/22 "Functional Capacity Screen" (FCS) identified R323 was unable to perform management of medications.

The 10/11/23 "Negotiated Service Agreement" (NSA) for R323 identified facility staff would provide management of medications.

R323's record lacked evidence of documentation of quarterly medication regimen reviews.

- Review of R324's record revealed an admission date of 05/25/22 with the following diagnoses: dementia with behaviors and anxiety.

The 05/25/22 "FCS" identified R324 was unable to perform management of medications.

The 05/25/22 "NSA" for R324 identified facility staff would provide management of medications.

R324's record lacked evidence of documentation of quarterly medication regimen reviews.

On 03/27/23 at 12:30 PM Administrative Staff A confirmed quarterly medication regimen reviews were not completed for the residents.

On 03/27/23 at 04:47 the facility's medication regimen review policy was requested which was not provided by the end of the survey.

The operator failed to ensure quarterly medication regimen reviews were conducted for R323 and R324.

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S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(a) The facility reported a census of seven residents. Based on interview and record review the operator failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within a locked area. Findings included: - Observation on 03/23/23 at 09:34 AM of laundry area revealed two side-by-side doors were unlocked. One door opened to the washing machine and the other door opened to the drying machine. Above each machine was an unlocked cabinet. Above the washing machine was a two-gallon plastic jug of Xtra laundry detergent with a label that read "Keep out of reach of children." Above the drying machine was a 32-ounce (oz) bottle of Scrubbing Bubbles Bathroom Grime Fighter, with a label that read "Keep out of reach of children."	S5335		

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S5335	Continued From page 24 Observation on 03/23/23 at 10:01 AM of bathroom two revealed the door was unlocked. In the bathroom was a cabinet under the sink with a lock attached to the door handles. The lock was unlocked with a 32-oz bottle of Lysol Advanced Power Clinging Gel inside the cabinet with a label that read "Keep out of reach of children." On 03/23/23 at 10:07 AM Certified Medication Aide (CMA) B confirmed chemicals were stored in a cabinet under the bathroom sink and in the laundry area that were not locked. On 03/27/23 at 04:47 the facility's chemical storage policy was requested which was not provided by the end of the survey. The operator failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within a locked area.	S5335		
S5380 SS=F	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)	S5380		

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S5380	Continued From page 25 The facility reported a census of seven residents. Based on observation and interview the operator failed to ensure water temperatures were maintained within a safe range between 98 degrees Fahrenheit (F) and 120 degrees F. The facility had two bathrooms which residents used. During initial tour of the facility, the hot water temperature in bathroom one measured 141.0 degrees F and the hot water temperature in bathroom two measured 146.4 degrees F. Findings included: - Observation on 03/23/23 at 09:45 AM revealed the water temperature in bathroom one sink was 141.0 degrees F. Observation on 03/23/23 at 10:01 AM revealed the water temperature in bathroom two sink was 146.4 degrees F. On 03/23/23 at 10:54 AM Certified Medication Aide (CMA) B turned down the water temperature setting on the hot water heater from high to low. She stated facility staff were responsible for obtaining water temperatures and documenting them on a paper log. She could not find the water temperature log or the facility's thermometer to verify water temperatures. On 03/27/23 at 04:47 PM the facility's water temperature policy was requested which was not provided by the end of the survey. The operator failed to ensure water temperatures were maintained within a safe range between 98 degrees Fahrenheit (F) and 120 degrees F.	S5380		

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