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	N089042	A. BUILDING: _____ B. WING _____	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF AUBURN	280 E VALLEY SPRINGS DR AUBURN, KS 66402

(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 citations represent the findings of the licensure resurvey with attached complaint numbers 180945, 180800, 180158,179885, and 179834 for the above named facility conducted on 06/21/23, 06/22/23 and 06/26/23.	S 000		
S3026 SS=K	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101 (f) (1) (B) The facility reported a census of 28 residents. Based on observation, interview, and record review the operator failed to provide services to all 28 "Residents" (R) in a manner that ensured the residents' safety and well-being, when the facility hosted two events, one on 05/05/23 and one on 05/18/23, and allowed staff, while on duty, to consume alcoholic beverages and then provide direct resident care. The operator further failed to ensure the safety of residents when an operator provided alcoholic beverages to an underage staff member, who then provided residents with direct care. This placed all	S3026		

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

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residents at risk for neglect and potential harm.

Findings included:

- Interview on 06/21/23 at 01:56 PM with Operator B stated the facility held an event on 05/05/23 at 01:00 PM for staff, residents and families for Cinco De Mayo. She continued that there were no families present during this event. She stated that she mixed the margaritas herself, and she used a bottle of tequila and a separate bottle of margarita mixer to mix the drinks. She stated she purchased 2 bottles of tequila and 2 bottles of margarita mixer for the event from the local liquor store. Operator B confirmed she allowed staff to consume 2 nine-ounce alcoholic margaritas while on duty and did not use any device to measure how much tequila was being poured into each drink.

Observation on 06/21/23 at 03:54 PM on the file cabinet in the office of Operator B sat a bottle of "Jose" tequila 40% with a scant amount of clear liquid in the bottom of the bottle. Also, a bottle of "Margarita" mix that contained approximately 1 inch of liquid in the bottom of the bottle. Operator B confirmed at the time of the observation that these were left over from the 05/05/23 Cinco De Mayo event.

Staff timecards for 05/05/23 recorded the following staff on duty at the time of the party with clock out times and interviews. The party started at 01:00PM.

Operator B clocked out at 05:00PM; interview on 6/21/23 at 01:56 PM, she stated she drank 2

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margaritas that contained alcohol.
"Licensed Nurse" (LN) C clocked out at 05:00 PM; interview on 06/21/23/at 02:53 PM she stated she consumed 2 margaritas.
Facility staff CC clocked out at 06:53 PM
Dietary Manager DD clocked out at 05:48 PM; Interview on 06/21/23 at approximately 05:00 PM; He stated he did not consume any alcohol at the event.
"Certified Nurse Aide" (CNA) EE clocked out at 03:06 PM
CNA JJ clocked out at 03:24 PM
CNA KK clocked out at 07:03 PM
Housekeeping staff LL clocked out at 03:01 PM

- Interview on 06/21/23 at 01:56 PM with Operator B, confirmed the facility had another event on 05/18/23 from 04:00 PM to 07:00 PM that included all staff, residents and families. She confirmed she had one staff member that was under the legal age of 21 years old. She stated that the facility served "Bud Light" standard 12-ounce cans or premixed margaritas in 9-ounce clear plastic cups. She continued that all alcohol had been purchased from the local liquor store. She stated she told staff they were allowed 2 alcoholic beverages while on the clock during the event. Operator B confirmed the party was held in the back secured courtyard with outside entertainment. She further confirmed her and Operator F from a sister facility poured and served the margaritas. Operator B's timecard revealed she was on the clock from 08:00 AM to 05:00 PM on 05/18/23.

Her signed witness statement revealed; On 05/18/23 beginning at 04:00 PM the facility

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hosted an event for residents, families and outside providers. The event included entertainment, appetizers and alcoholic beverages of beer and margaritas. The alcohol was served at approximately 05: (illegible number) PM. The statement continued to state that the operator consumed 3 margaritas that were premixed in a 9-ounce cup, and that staff members were allowed 2 beverages each. "The director from the facility in Topeka" was assisting the operator to serve the drinks.

Interview on 06/21/23 at 02:53 PM with LN C, she stated that on 05/05/23 at approximately 01:00 PM she drank 2 margaritas that contained alcohol at the event hosted by the facility. She continued, that at the event on 05/18/23 she had 2.5 "Bud Light" beers. She stated she told staff that was on duty at the time, they could have 3 "beers" /3 "reasonably sized" drinks.. She defined "reasonably sized" as no more than 12 ounces. Her timecard recorded she worked until 05:00 PM that day. Her signed witness statement confirmed she consumed 2.5 beers that day while on duty.

Interview on 06/21/23 with "Certified Medication Aide" (CMA) II she stated she had one strawberry margarita at the event on 05/18/23. Her timecard revealed she worked until 07:02 PM that day. Her signed witness statement confirmed she drank one margarita and worked until 07:00 PM that day.

Interview on 06/21/23 at 04:19 PM with CNA HH

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confirmed he was 18 years old. He stated he was working during the time of the event on 05/18/23 and that he consumed two margaritas. He stated Operator F (from a different facility), who was at the event, provided him the margaritas that contained alcohol. CNA HH's timecard recorded he worked until 09:53 PM that day and his signed witness statement revealed he was handed alcohol containing tequila by Operator F at that party.

Interview on 06/21/23 at 05:01 PM with CNA GG, she stated she did not drink but was concerned seeing an underage staff member with a drink in his hand. She did not have concerns of other staff and the consumption of alcohol. Her timecard recorded she worked from 06:53 PM until 07:06 AM the next day.

Interview on 06/21/23 at 07:06 PM with CNA FF, she confirmed the event was still in progress at the time of her arrival for her shift at 07:00 PM. She stated staff and residents were outside. She continued that Operator B offered her a drink/margarita and CNA FF accepted it. CNA FF stated that Operator B asked her to go to a resident room at one resident's request and retrieve a bottle of "Jack Daniels". CNA FF then stated the resident poured "Jack and Coke" drinks. CNA FF confirmed she drank a "Jack and Coke" and a margarita that night. CNA FF continued to state that Operator B and LN C were "very inebriated". Her timecard recorded she worked from 07:00 PM that day until 07:00 AM the next day.

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S3026	Continued From page 5 Record review of the facility provided Employee Handbook revealed the following: On page 7, under the section titled "Drug and Alcohol-Free Workplace" it states, "It is strictly prohibited to manufacture, distribute, possess, use or be under the influence of alcohol or an illegally used controlled substance, including prescription medications, on employer premises, in employer vehicles or while engaged in employer activities". The operator failed to provide services to all 28 residents in a manner that ensured each resident's safety and well-being, when the facility hosted two events, one on 05/05/23 and one on 05/18/23, that allowed staff, while on duty, to consume alcoholic beverages and then provide direct resident care, and further provided alcoholic beverages to one staff member who was 18 years old, under the legal drinking age of 21, at the event on 05/18/23. This placed all residents at risk for neglect and potential harm.	S3026		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department.	S3080		

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S3080	Continued From page 6 (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: Surveyor: Maxwell, Shanie KAR 26-41-201 (a) The facility reported a census of 28 residents. The sample included seven "Residents" (R)'s 1, 2, 3, 4, 5, 6 and 7. Based on interview and record review the operator failed to conduct a screening to determine the functional capacity for R1 prior to or at the time of admission when he was admitted to the facility on 06/19/23 and the "Functional Capacity Screening" (FCS) was not completed until 06/21/23. Findings included: - Record review on 06/21/23 revealed an admission date of 06/19/23 with admitting diagnoses of unspecified cerebral infarction, vascular dementia, unspecified glaucoma, unspecified hearing loss, essential hypertension, peripheral vascular disease, gross hematuria, cellulitis of right upper limb, localized swelling, mass and lump unspecified, and anxiety disorder. Review of R1 combined and unsigned "Functional Capacity Screen / Negotiated Service Agreement" (FCS/NSA) dated 06/21/23 and identified R1 required supervision with bathing, dressing, toileting, and eating. He was independent with transferring, walking, and	S3080		

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S3080	Continued From page 7	S3080		

lacked the ability to manage his own medication and medical treatments. He was usually incontinent, and had impaired short-term memory, long-term memory, memory recall and decision making. He was usually able to make himself understood and usually he understood others. He was marked with impaired vision and impaired hearing; he used no mobility device.

Review of R1 combined and unsigned FCS/NSA dated 06-21-23 identified the facility would provide the following healthcare services: oversight and reminders for bathing, dressing, toileting, and eating. The facility staff would provide/manage R1 medications and medical treatments.

Review on R1 "Health Service Plan" (HSP) dated 06/21/23 under the "Focus" heading listed "Activities" with the "Goals" of; R1 would attend activities, expression satisfaction with type of activities and level of activity involvement when asked and will maintain involvement is stimulating and socially engaging activities. Under the "Focus" of "Activities of Daily Living" it stated "Independent", and goal was R1 would maintain current level of functioning. The document lacked interventions.

Review of R1 "Addendum to Negotiated Service Agreement" dated 06/23/23 revealed R1 legal representative signed it on 06/23/23.

Review of R1 "Electronic Medication Administration Record" (EMAR) revealed the facility did not document administration of medications provided to R1 until 06/21/23.

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S3080	Continued From page 8 Review of R1 electronic progress notes dated 06/19/23 to 06/22/23 revealed there were no notes in the electronic record. Interview on 06/22/23 at approximately 01:45 PM with "Licensed Nurse" (LN) C, she confirmed R1 was admitted to the facility on 06/19/23, she further confirmed the FCS determining R1 level of functional capacity was not performed until 06/21/23. She continued the family "dropped off" the resident and she was unaware that the family was going to leave R1 at the facility at this time. She continued to state that R1 wife brought in a current medication list for R1 and set the medications up in medication cups so that the facility staff could administer them. LN C confirmed she did not receive physician orders for R1 until 06/23/23. LN C continued to state that R1 wife provided verbal instructions to her on how to care for R1. The operator failed to conduct a screening to determine the functional capacity for R1 prior to or at the time of admission when he was admitted to the facility on 06/19/23 and the "Functional Capacity Screening" (FCS) was not completed until 06/21/23, 3 days later.	S3080		
S3085 SS=D	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	S3085		

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S3085	Continued From page 9 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) The facility reported a census of 28 residents. The sample included seven "Residents" (R)'s 1, 2, 3, 4, 5, 6 and 7. Based on interview and record review the operator failed to ensure the development of a written "Negotiated Service Agreement" (NSA) at the time of admission on 06/19/23, for R1 that was based on the "Functional Capacity Screen" (FCS), and provided a description of the services R1 would receive, identification of the provider of each service, and identification of each party responsible for payment if outside resources provided a service. Findings included: - Record review on 06/21/23 revealed an admission date of 06/19/23 with admitting diagnoses of unspecified cerebral infarction, vascular dementia, unspecified glaucoma, unspecified hearing loss, essential hypertension,	S3085		

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peripheral vascular disease, gross hematuria, cellulitis of right upper limb, localized swelling, mass and lump unspecified, and anxiety disorder.

Review of R1 combined and unsigned "Functional Capacity Screen / Negotiated Service Agreement" (FCS/NSA) dated 06/21/23 and identified R1 required supervision with bathing, dressing, toileting, and eating. He was independent with transferring, walking, and lacked the ability to manage his own medication and medical treatments. He was usually incontinent, and had impaired short-term memory, long-term memory, memory recall and decision making. He was usually able to make himself understood and usually he understood others. He was marked with impaired vision and impaired hearing; he used no mobility device.

Review of R1 combined and unsigned FCS/NSA dated 06-21-23, identified the facility would provide the following healthcare services: oversight and reminders for bathing, dressing, toileting, and eating. The facility staff would provide/manage R1 medications and medical treatments.

Review on R1 "Health Service Plan" (HSP) dated 06/21/23 under the "Focus" heading listed "Activities" with the "Goals" of; R1 would attend activities, expression satisfaction with type of activities and level of activity involvement when asked and will maintain involvement is stimulating and socially engaging activities. Under the "Focus" of "Activities of Daily Living" it stated "Independent", and goal was R1 would maintain current level of functioning. The

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document lacked interventions.

Review of R1 "Addendum to Negotiated Service Agreement" dated 06/23/23 revealed R1 legal representative signed it on 06/23/23.

Review of R1 "Electronic Medication Administration Record" (EMAR) revealed the facility did not document administration of medications provided to R1 until 06/21/23.

Review of R1 electronic progress notes dated 06/19/23 to 06/22/23 revealed there were no notes in the electronic record.

Interview on 06/22/23 at approximately 01:45 PM with "Licensed Nurse" (LN) C, she confirmed R1 was admitted to the facility on 06/19/23, she further confirmed the FCS determining R1 level of functional capacity was not performed until 06/21/23. She continued the family "dropped off" the resident and she was unaware that the family was going to leave R1 at the facility at this time. She continued to state that R1 wife brought in a current medication list for R1 and set the medications up in medication cups so that the facility staff could administer them. LN C confirmed she did not receive physician orders for R1 until 06/23/23. LN C continued to state that R1 wife provided verbal instructions to her on how to care for R1.

The operator failed to ensure the development of a written "Negotiated Service Agreement" (NSA) at the time of admission on 06/19/23, for R1 that was based on the "Functional Capacity Screen" (FCS) and provided a description of the services R1 would receive, identification of the provider of

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S3085	Continued From page 12 each service, and identification of each party responsible for payment if outside resources provided a service.	S3085		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (h) The facility reported a census of 28 residents. The sample included seven "Residents'" (R)'s 1, 2, 3, 4, 5, 6 and 7. Based on interview and record review the operator failed to ensure that each individual involved in the development of the "Negotiated Service Agreement" (NSA), shall sign the agreement. Record review revealed R2, R3, R4, R5 and R6 NSA lacked signatures of each individual involved in the development of the NSA. Findings included: - Record review on 06/21/23 for R2 revealed an admission date of 06/03/22 with diagnoses of polymyositis with organ involvement, common variable immunodeficiency, generalized anxiety disorder, essential hypertension, glaucoma,	S3101		

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S3101	Continued From page 13 other reduced mobility, need for assistance with personal care, and type two diabetes. Record review of R2 combined "Functional Capacity Screen/Negotiated Service Agreement" (FCS/NSA) dated 03/03/23 revealed R2 required physical assistance with bathing. She was independent with dressing, transferring, mobility, eating and toileting. She used a wheelchair mobility device, had intact cognition. She was marked with administering some of her own medications and the facility administering some. She was able to make herself understood and she understood others, and she was continent of her bladder. R2's combined FCS/NSA lacked a signature of each individual involved in the development of the NSA. - Record review on 06/21/23 for R3 revealed an admission date of 07/01/22 with diagnoses of vertigo of central origin, absolute glaucoma unspecified eye, bradycardia, repeated falls, cirrhosis of the liver, abnormalities of gait and mobility, history of falling, muscle weakness, need for assistance with personal care, cognitive communication deficit, malignant neoplasm of unspecified site of unspecified female breast, transient cerebral ischemic attack, and atrial fibrillation. Record review of R3 combined FCS/NSA dated 03/02/23 revealed R3 was independent with bathing, dressing, toileting, and walking. She required supervision with her medications and	S3101		

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S3101	Continued From page 14 facility staff were marked as responsible for medication administration. She was continent of her bladder. She was marked with intact short-term memory, and impaired long-term memory, memory recall, and decision making. She was able to make herself understood and she understood others. R3's combined FCS/NSA lacked a signature of each individual involved in the development of the NSA. - Record review for R4 revealed an admission date of 12/12/22 with diagnoses of pain, unspecified dementia, anxiety disorder, depression, and essential hypertension. Record review of R4 combined FCS/NSA dated 12/12/22 revealed R4 required physical assistance from staff with bathing, dressing, toileting, walking, and facility nurse to prepare and administer her medications. She was independent with eating, was usually incontinent of bladder, had impaired short-term memory, impaired memory recall and impaired decision making. She was able to make herself understood and she understood others. She was marked with falls and impaired decision making. R4's combined FCS/NSA lacked a signature of each individual involved in the development of the NSA. - Record review for R5 revealed an admission date of 12/17/21 with diagnoses of essential hypertension, pneumonia unspecified organism,	S3101		

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S3101	Continued From page 15 acute cystitis, alcohol abuse, alcohol dependence with alcohol induced persisting dementia, non-traumatic subarachnoid hemorrhage, and type two diabetes. Record review of R5's combined FCS/NSA dated 03/28/23 revealed R5 required staff supervision with bathing, and staff physical assistance with dressing. He was independent with toileting, transferring, walking/mobility with the use of a cane, and facility staff to manage and administer his medications. He was continent of his bladder, and had impaired long-term memory, memory recall and impaired decision making. He was able to make himself understood and he understood others. He was marked with impaired vision, and impaired decision making. R5's combined FCS/NSA lacked a signature of each individual involved in the development of the NSA. - Record for R6 revealed an admission date of 01/17/22 with diagnoses of acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity, saddle embolus of pulmonary artery without acute cor pulmonale, chronic idiopathic constipation, major depressive disorder, edema, peripheral vascular disease, chronic kidney disease stage three. Record review of R6's combined FCS/NSA dated 07/13/22 revealed R6 required physical assistance from facility staff for: bathing, dressing, toileting, transferring, mobility, and management of her medication administration and medical treatments. She was frequently	S3101		

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S3101	Continued From page 16 incontinent of her bladder and scored with intact cognition. She was able to make herself understood and she understood others. She was marked with falls and used a wheelchair mobility device. R6's combined FCS/NSA lacked a signature of each individual involved in the development of the NSA. Record review of the "Electronic Mail" (Email) provided by operator B, She confirmed she was unable to locate the combined signed FCS/NSAs. The operator failed to ensure that each individual involved in the development of the "Negotiated Service Agreement" (NSA), shall sign the agreement. Record review revealed R2, R3, R4, R5 and R6 NSA lacked signatures of each individual involved in the development of the NSA.	S3101		
S3155 SS=D	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S3155		

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S3155	Continued From page 17 This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (a) The facility reported a census of 28 residents. The sample included seven "Residents" (R)'s 1, 2, 3, 4, 5, 6 and 7. Based on interview and record review the operator failed to ensure the "Licensed Nurse" (LN) provided or coordinated the provision of necessary health care services that met the needs for R1 when he admitted to the facility on 06/19/23 and a review of the resident records showed the combined "Functional Capacity Screen/Negotiated Service Agreement" (FCS/NSA) were not completed until 06/21/23. Findings included: - Record review on 06/21/23 revealed an admission date of 06/19/23 with admitting diagnoses of unspecified cerebral infarction, vascular dementia, unspecified glaucoma, unspecified hearing loss, essential hypertension, peripheral vascular disease, gross hematuria, cellulitis of right upper limb, localized swelling, mass and lump unspecified, and anxiety disorder. Review of R1 combined and unsigned "Functional Capacity Screen / Negotiated Service Agreement" (FCS/NSA) dated 06/21/23 and identified R1 required supervision with bathing, dressing, toileting, and eating. He was independent with transferring, walking, and lacked the ability to manage his own medication and medical treatments. He was usually	S3155		

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S3155	Continued From page 18 incontinent, and had impaired short-term memory, long-term memory, memory recall and decision making. He was usually able to make himself understood and usually he understood others. He was marked with impaired vision and impaired hearing; he used no mobility device. Review of R1 combined and unsigned FCS/NSA dated 06-21-23, identified the facility would provide the following healthcare services: oversight and reminders for bathing, dressing, toileting, and eating. The facility staff would provide/manage R1 medications and medical treatments. Review on R1 "Health Service Plan" (HSP) dated 06/21/23 under the "Focus" heading listed "Activities" with the "Goals" of; R1 would attend activities, expression satisfaction with type of activities and level of activity involvement when asked and will maintain involvement is stimulating and socially engaging activities. Under the "Focus" of "Activities of Daily Living" it stated "Independent", and goal was R1 would maintain current level of functioning. The document lacked interventions. Review of R1 "Addendum to Negotiated Service Agreement" dated 06/23/23 revealed R1 legal representative signed it on 06/23/23. Review of R1 "Electronic Medication Administration Record" (EMAR) revealed the facility did not document administration of medications provided to R1 until 06/21/23. Review of R1 electronic progress notes dated 06/19/23 to 06/22/23 revealed there were no	S3155		

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S3155	Continued From page 19 notes in the electronic record. Interview on 06/22/23 at approximately 01:45 PM with "Licensed Nurse" (LN) C, she confirmed R1 was admitted to the facility on 06/19/23, she further confirmed the FCS determining R1 level of functional capacity was not performed until 06/21/23. She continued the family "dropped off" the resident and she was unaware that the family was going to leave R1 at the facility at this time. She continued to state that R1 wife brought in a current medication list for R1 and set the medications up in medication cups so that the facility staff could administer them. LN C confirmed she did not receive physician orders for R1 until 06/23/23. LN C continued to state that R1 wife provided verbal instructions to her on how to care for R1. The operator failed to ensure the "Licensed Nurse" (LN) provided or coordinated the provision of necessary health care services that met the needs for R1 when he admitted to the facility on 06/19/23 and a review of the resident records showed the combined "Functional Capacity Screen/Negotiated Service Agreement" (FCS/NSA) were not completed until 06/21/23.	S3155		
S3166 SS=E	26-41-204 (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.	S3166		

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S3166	Continued From page 20 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (e) The facility reported a census of 28 residents. Based on interview and record review the operator failed to ensure the "Licensed Nurse" (LN) documented delegated nursing procedures not included in the medication aide curriculum related to obtaining a fingerstick blood sugar for "Certified Medication Aide's" (CMA) II and CMA MM, and further failed to ensure the LN documented the delegated nursing procedures for CMA MM on dialing the insulin pens for diabetic residents. Findings included: - Record review on 06/22/23 of newly hired CMA II employee record revealed a hire date of 09/16/22. The record contained a document titled "Competency Checklist" for "Flexpen and Flextouch Insulin Pens" and was signed and dated on 11/11/22. CMA II record lacked a completed competency check list for obtaining a finger stick blood sugar. Record review on 06/22/23 of newly hired CMA MM employee record revealed a hire date of 12/05/22. The employee record for CMA MM lacked documentation of a completed competency check list for obtaining a finger stick blood sugar, and further lacked a completed competency check list for dialing the resident insulin pen.	S3166		

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S3166	Continued From page 21 Record review on 06/26/23 of the "Electronic Mail" (Email) sent by Operator B, she confirmed she "was unable to locate" completed nursing delegation forms for CMA MM. The operator failed to ensure the "Licensed Nurse" (LN) documented delegated nursing procedures not included in the medication aide curriculum related to obtaining a fingerstick blood sugar for "Certified Medication Aide's" (CMA) II and CMA MM, and further failed to ensure the LN documented the delegated nursing procedures for CMS MM on dialing the insulin pens for diabetic residents.	S3166		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (i) The facility reported a census of 28 residents. The sample included seven "Residents'" (R)'s 1, 2, 3, 4, 5, 6 and 7. Based on interview and record review the operator failed to ensure that all health care services were provided to R2 by qualified staff in accordance with acceptable standards of practice when they failed to do an assessment of the bed assist device attached to the upper left side of her bed, to ensure it was	S3171		

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not a restraint, to determine the purpose of the device, to determine that it was securely attached to the bed/bedframe, assess R2 ability to safely use the device and provide a periodic reassessment of the device.

Findings included:

- Record review on 06/21/23 for R2 revealed an admission date of 06/03/22 with diagnoses of polymyositis with organ involvement, common variable immunodeficiency, generalized anxiety disorder, essential hypertension, glaucoma, other reduced mobility, need for assistance with personal care, and type two diabetes.

Record review of R2 combined "Functional Capacity Screen/Negotiated Service Agreement" (FCS/NSA) dated 03/03/23 revealed R2 required physical assistance with bathing. She was independent with dressing, transferring, mobility, eating and toileting. She used a wheelchair mobility device, had intact cognition. She was marked with administering some of her own medications and the facility administering some. She was able to make herself understood and she understood others, and she was continent of her bladder. She had oxygen equipment, a hospital bed, and a bed cane.

The combined FCS/NSA lacked a description of the bed assist device.
R2 electronic record lacked an assessment of the device ensuring it was not a restraint, to determine the purpose of the device, to determine that it was securely attached to the bed/bedframe, assess R2 ability to safely use the

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device and provide a periodic reassessment of the device.

Observation on 06/22/23 at 04:15 PM of R2's bed, revealed on the left upper portion of the bed closest to the south wall, was a rail attached to the bed frame that measured 32 inches in width, 13 inches in length on the outer left and outer right side of the rail, and 17 inches in length in the center part of the rail.

Interview on 06/22/23 at approximately 05:00 PM with operator B, licensed nurse C, and regional vice president D, they confirmed the record lacked an assessment for the bed assist device.

According to the "United States Food and Drug Administration" (FDA), they recommend that an assessment be performed to confirm the device is not a restraint, to determine the purpose of the device and the residents ability to safely use the device, assess to ensure it is securely attached to the bed and measure to ensure that it poses no rise for entrapment, should be listed on the resident FCS, a description of the device in the NSA, and document periodic reassessments of the resident's use of the device and their ability to use it safely and document it in the resident record.
http://www.fda.gov/MedicalDevices/ProcuctsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/defult.htm

The operator failed to ensure that all health care services were provided to R2 by qualified staff in accordance with acceptable standards of practice when they failed to do an assessment of the bed assist device attached to the upper left

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S3171	Continued From page 24 side of her bed, to ensure it was not a restraint, to determine the purpose of the device, to determine that it was securely attached to the bed/bedframe, assess R2 ability to safely use the device and provide a periodic reassessment of the device.	S3171		
S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (b) The facility reported a census of 28 residents. The sample included seven "Resident's" (R)'s 1, 2, 3, 4, 5 ,6 and 7. Based on observation interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for R2 identified which medications she would self-administer. Findings included:	S3186		

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S3186	Continued From page 25 - Record review on 06/21/23 for R2 revealed an admission date of 06/03/22 with diagnoses of polymyositis with organ involvement, common variable immunodeficiency, generalized anxiety disorder, essential hypertension, glaucoma, other reduced mobility, need for assistance with personal care, and type two diabetes. Review of R2 combined and unsigned "Functional Capacity Screen/Negotiated Service Agreement" (FCS) dated 03/23/23 identified R2 required physical assistance from facility staff with bathing. She was independent with dressing, toileting, transferring, walking/mobility, and eating. She required physical assistance with her medications and was marked with "resident self-medicates some of their medications". She was marked as having oxygen equipment, a hospital bed and a bed cane. The combined FCS/NSA did not identify which medications the resident would self-administer. Record review of the R2 self-administration of medication assessment did not identify which medications the resident would self-administer. Observation on 06/23/22 at 04:15 PM during interview with R2, revealed a clear plastic medication cup with a pill in the cup sitting on top of the television table at the east end of the couch. R2 stated she "doesn't usually take medications at the time they are provided". Interview with "Certified Medication Aide" (CMA) II on 06/22/23 at approximately 05:00 PM, she confirmed that R2 is the only resident she leaves a pill with to self-administer.	S3186		

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S3186	Continued From page 26 The operator failed to ensure the "Negotiated Service Agreement" (NSA) for R2 identified which medications she would self-administer.	S3186		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) The facility reported a census of 28 residents. The sample included seven "Residents" (R)'s 1, 2, 3, 4, 5, 6 and 7. Based on interview and record review the operator failed to ensure the "Licensed Nurse" (LN) ensured all medications administered to R1 by facility staff were	S3200		

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administered in accordance with a medical care provider's written order, professional standards of practice, and each manufacturers recommendations when R1 admitted to the facility on 06/19/23.

Findings included:

- Record review on 06/21/23 revealed an admission date of 06/19/23 with admitting diagnoses of unspecified cerebral infarction, vascular dementia, unspecified glaucoma, unspecified hearing loss, essential hypertension, peripheral vascular disease, gross hematuria, cellulitis of right upper limb, localized swelling, mass and lump unspecified, and anxiety disorder.

Review of R1 combined and unsigned "Functional Capacity Screen / Negotiated Service Agreement" (FCS/NSA) dated 06/21/23 and identified R1 required supervision with bathing, dressing, toileting, and eating. He was independent with transferring, walking, and lacked the ability to manage his own medication and medical treatments. He was usually incontinent, and had impaired short-term memory, long-term memory, memory recall and decision making. He was usually able to make himself understood and usually he understood others. He was marked with impaired vision and impaired hearing; he used no mobility device.

Review of R1 combined and unsigned FCS/NSA dated 06/21/23, identified the facility would provide the following healthcare services: oversight and reminders for bathing, dressing, toileting, and eating. The facility staff would

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S3200	Continued From page 28 provide/manage R1 medications and medical treatments. Review on R1 "Health Service Plan" (HSP) dated 06/21/23 under the "Focus" heading listed "Activities" with the "Goals" of; R1 would attend activities, expression satisfaction with type of activities and level of activity involvement when asked and will maintain involvement is stimulating and socially engaging activities. Under the "Focus" of "Activities of Daily Living" it stated "Independent", and goal was R1 would maintain current level of functioning. The document lacked interventions. Review of R1 "Addendum to Negotiated Service Agreement" dated 06/23/23 revealed R1 legal representative signed it on 06/23/23. Review of R1 "Electronic Medication Administration Record" (EMAR) revealed the facility did not document administration of medications provided to R1 until 06/21/23. Review of R1 electronic progress notes dated 06/19/23 to 06/22/23 revealed there were no notes in the electronic record. Interview on 06/22/23 at approximately 01:45 PM with "Licensed Nurse" (LN) C, she confirmed R1 was admitted to the facility on 06/19/23, she further confirmed the FCS determining R1 level of functional capacity was not performed until 06/21/23. She continued the family "dropped off" the resident and she was unaware that the family was going to leave R1 at the facility at this time. She continued to state that R1 wife brought in a current medication list for R1 and set the	S3200		

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S3200	Continued From page 29 medications up in medication cups so that the facility staff could administer them. LN C confirmed she did not receive physician orders for R1 until 06/23/23. LN C continued to state that R1 wife provided verbal instructions to her on how to care for R1. The operator failed to ensure the "Licensed Nurse" (LN) ensured all medications administered to R1 by facility staff were administered in accordance with a medical care provider's written order, professional standards of practice, and each manufacturers recommendations when R1 admitted to the facility on 06/19/23.	S3200		
S3201 SS=D	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered.	S3201		

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S3201	Continued From page 30	S3201		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-205 (d) (3) (A) (D)

The facility reported a census of 28 residents. The sample included seven "Residents" (R)'s 1, 2, 3, 4, 5, 6 and 7. Based on interview and record review, the operator failed to ensure the "Licensed Nurse" (LN) ensured all medications administered to R1 by facility staff, personally prepared and documented the actual time of administration of each medication in R1's medication administration record, when R1 admitted to the facility on 06/19/23.

Findings included:

- Record review on 06/21/23 revealed an admission date of 06/19/23 with admitting diagnoses of unspecified cerebral infarction, vascular dementia, unspecified glaucoma, unspecified hearing loss, essential hypertension, peripheral vascular disease, gross hematuria, cellulitis of right upper limb, localized swelling, mass and lump unspecified, and anxiety disorder.

Review of R1 combined and unsigned "Functional Capacity Screen / Negotiated Service Agreement" (FCS/NSA) dated 06/21/23 and identified R1 required supervision with bathing, dressing, toileting, and eating. He was independent with transferring, walking, and lacked the ability to manage his own medication and medical treatments. He was usually incontinent, and had impaired short-term

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S3201	Continued From page 31	S3201		

memory, long-term memory, memory recall and decision making. He was usually able to make himself understood and usually he understood others. He was marked with impaired vision and impaired hearing; he used no mobility device.

Review of R1 combined and unsigned FCS/NSA dated 06/21/23, identified the facility would provide the following healthcare services: oversight and reminders for bathing, dressing, toileting, and eating. The facility staff would provide/manage R1 medications and medical treatments.

Review on R1 "Health Service Plan" (HSP) dated 06/21/23 under the "Focus" heading listed "Activities" with the "Goals" of; R1 would attend activities, expression satisfaction with type of activities and level of activity involvement when asked and will maintain involvement is stimulating and socially engaging activities. Under the "Focus" of "Activities of Daily Living" it stated "Independent", and goal was R1 would maintain current level of functioning. The document lacked interventions.

Review of R1 "Addendum to Negotiated Service Agreement" dated 06/23/23 revealed R1 legal representative signed it on 06/23/23.

Review of R1 "Electronic Medication Administration Record" (EMAR) revealed the facility did not document administration of medications provided to R1 until 06/21/23.

Review of R1 electronic progress notes dated 06/19/23 to 06/22/23 revealed there were no notes in the electronic record.

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S3201	Continued From page 32 Interview on 06/22/23 at approximately 01:45 PM with "Licensed Nurse" (LN) C, she confirmed R1 was admitted to the facility on 06/19/23, and the FCS determining R1 level of functional capacity was not performed until 06/21/23. She continued the family "dropped off" the resident and she was unaware that the family was going to leave R1 at the facility at this time. She continued to state that R1 wife brought in a current medication list for R1 and set the medications up in medication cups so that the facility staff could administer them. LN C confirmed she did not receive physician orders for R1 until 06/23/23. LN C continued to state that R1 wife provided verbal instructions to her on how to care for R1. The operator failed to ensure the "Licensed Nurse" (LN) ensured all medications administered to R1 by facility staff, personally prepared and documented the actual time of administration of each medication in R1's medication administration record, when R1 admitted to the facility on 06/19/23.	S3201		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (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	S3211		

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S3211	Continued From page 33 place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: K.A.R.26-41-205 (g) (3) The facility reported a census of 28 residents. Based on observation and interview the operator failed to ensure a licensed nurse or a licensed pharmacist placed the full name of the resident on the "Over the Counter" (OTC) medications located in the facility medication cart. Findings included: - Observation on 06/21/23 at 09:07 AM during the initial facility tour of the facility medication room revealed the following: "Certified Medication Aide" (CMA) II opened the locked medication cart. In the cart were the following unlabeled OTC medications: 1 bottle of Melatonin 5 milligrams with a first and last initial on the top of the bottle. 1 bottle of Meclizine 25 milligrams with a resident first name only on the top of the bottle. 1 bottle of Acetaminophen Extra Strength 1 bottle of Aleve 1 bottle of Bayer back and body Interview during the medication cart review, CMA II confirmed the OTC's lacked the full name of the residents. Interview on 06/21/23 at approximately 11:00 AM	S3211		

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S3211	Continued From page 34 with "Licensed Nurse" (LN) C and Operator B, they confirmed the OTC medications did not contain the full name of the residents. The operator failed to ensure a licensed nurse or a licensed pharmacist placed the full name of the resident on the "Over the Counter" (OTC) medications located in the facility medication cart.	S3211		
S3215 SS=E	26-41-205 (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 facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy	S3215		

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S3215	Continued From page 35 provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (h) (4) The facility reported a census of 28 residents. Based on observation, interview and record review the operator failed to ensure licensed nurses could not administer medication beyond the manufacturers or pharmacy providers recommended date of expiration regarding insulin pens for "Residents" (R)'s 9, 10, 11, and 12 , and for the facility's Tubersol testing solution. Findings included: - Observation on 06/21/23 at approximately 09:40 AM during the initial facility tour in the medication room, "Certified Medication Aide" (CMA) II opened the locked medication cart, in the upper left-hand drawer were the following undated insulin pens: 1 Novolog flex pen that was empty and 1 Victoza pen that was halfway between 9 and 12 milligrams and labeled with "Resident" (R) 9's name. The date opened was not documented on the pens.	S3215		

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S3215	Continued From page 36 1 Novolog flex pen that was full and 1 Basaglar pen that was full and labeled with R 10's name. The date opened was not documented on the pens. 1 Tresiba flex pen that was full and labeled with R 11's name. The date opened was not documented on the pen. 1 Novolog flex pen that was full, and 1 Basaglar pen that was half full and labeled with R 12's name. The date opened was not documented on the pens. Record review of facility provided document titled "Insulin Pen Instructions" revealed the following statement: " Date the pen when it is used for the first time". Manufacturers instructions for the Novolog 70/30 flex pen state "Store the injection pen at room temperature (do not refrigerate) and use within 14 days". Manufacturers recommendation for Basaglar insulin pens state "Throw away the pen you are using after 28 days, even if it still has insulin left in it". Manufacturers Tresiba insulin pen is the "pen must be discarded after 6 weeks". - Observation on 06/21/23 at approximately 0950 AM of the small refrigerator in the medication room revealed 5 boxes of Tubersol solution. One box was opened and dated 03/23/23, a second box was opened and dated 05/17/23.	S3215		

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S3215	Continued From page 37 Manufacturers instructions for the Tubersol solution state the following "A vial of Tubersol which has been entered and in use for 30 days should be discarded". The operator failed to ensure licensed nurses could not administer medication beyond the manufacturers or pharmacy providers recommended date of expiration regarding insulin pens for "Residents" (R)'s 9, 10, 11, and 12 , and for the facility's Tubersol testing solution.	S3215		
S3261 SS=E	26-41-105 (f) (11) Resident Record 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: K.A.R. 26-41-105 (f) (11) The facility reported a census of 28 residents. The sample included seven "Residents'" (R)'s 1, 2, 3, 4, 5, 6, and 7. Based on record review and interview the operator failed to ensure the documentation of all incidents, symptoms, and any other indications of illness or injury including the date, time of occurrence, actions taken and results of the actions for R1 and R3.	S3261		

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S3261	Continued From page 38 Findings included: - Record review on 06/21/23 revealed an admission date of 06/19/23 with admitting diagnoses of unspecified cerebral infarction, vascular dementia, unspecified glaucoma, unspecified hearing loss, essential hypertension, peripheral vascular disease, gross hematuria, cellulitis of right upper limb, localized swelling, mass and lump unspecified, and anxiety disorder. Review of R1 combined and unsigned "Functional Capacity Screen / Negotiated Service Agreement" (FCS/NSA) dated 06/21/23 and identified R1 required supervision with bathing, dressing, toileting, and eating. He was independent with transferring, walking, and lacked the ability to manage his own medication and medical treatments. He was usually incontinent, and had impaired short-term memory, long-term memory, memory recall and decision making. He was usually able to make himself understood and usually he understood others. He was marked with impaired vision and impaired hearing; he used no mobility device. Review of R1 combined and unsigned FCS/NSA dated 06/21/23, identified the facility would provide the following healthcare services: oversight and reminders for bathing, dressing, toileting, and eating. The facility staff would provide/manage R1 medications and medical treatments. Review on R1 "Health Service Plan" (HSP) dated 06/21/23 under the "Focus" heading listed	S3261		

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S3261	Continued From page 39 "Activities" with the "Goals" of; R1 would attend activities, expression satisfaction with type of activities and level of activity involvement when asked and will maintain involvement is stimulating and socially engaging activities. Under the "Focus" of "Activities of Daily Living" it stated "Independent", and goal was R1 would maintain current level of functioning. The document lacked interventions. Review of R1 "Electronic Medication Administration Record" (EMAR) revealed the facility did not document administration of medications provided to R1 until 06/21/23. Review of R1 electronic progress notes dated 06/19/23 to 06/22/23 revealed there were no notes in the electronic record. Interview on 06/22/23 at approximately 01:45 PM with "Licensed Nurse" (LN) C, she confirmed R1 was admitted to the facility on 06/19/23, she further confirmed the FCS determining R1 level of functional capacity was not performed until 06/21/23. She continued the family "dropped off" the resident and she was unaware that the family was going to leave R1 at the facility at this time. She continued to state that R1 wife brought in a current medication list for R1 and set the medications up in medication cups so that the facility staff could administer them. LN C confirmed she did not receive physician orders for R1 until 06/23/23. LN C continued to state that R1 wife provided verbal instructions to her on how to care for R1 and she did not complete a progress note in the resident records of R1's admission to the facility.	S3261		

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S3261	Continued From page 40 - Record review on 06/21/23 for R3 revealed an admission date of 07/01/22 with diagnoses of vertigo of central origin, absolute glaucoma unspecified eye, bradycardia, repeated falls, cirrhosis of the liver, abnormalities of gait and mobility, history of falling, muscle weakness, need for assistance with personal care, cognitive communication deficit, malignant neoplasm of unspecified site of unspecified female breast, transient cerebral ischemic attack, and atrial fibrillation. Record review of R3 combined FCS/NSA dated 03/02/23 revealed R3 was independent with bathing, dressing, toileting, and walking. She required supervision with her medications and facility staff were marked as responsible for medication administration. She was continent of her bladder. She was marked with intact short-term memory, and impaired long-term memory, memory recall, and decision making. She was able to make herself understood and she understood others. Record review of R3 electronic progress notes dated 04/05/23 to 04/21/23 revealed the following note: 04/17/23 at 11:23 AM nurse note; "on Wednesday, April 12, 2023 nursing staff called this nurse at 2119 and stated that R3 called staff and stated that she had went in her bathroom and when she did she stated that the toe of her shoes caught the linoleum on the bathroom floor just right and she tripped and fell forward. When she fell forward she hit her left upper arm (humerus)on the bathroom sink. Vitals were taken at this time and were within normal limits.	S3261		

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S3261	Continued From page 41 R2 denied any weakness, dizziness, and stated the pain level was "low". There was bruising to the area and a golf ball sized knot to the left upper brachial. R3 refused hospitalization at this time. She stated she did not feel it was necessary. Staff provided an ice pack and advised R3 to elevate the arm for the night. Phone call to daughter but no answer. This nurse assessed this injury on Thursday, April 13th. No changes at this time. Vitals within normal limits. This nurse assessed this injury again on Friday April 14th. The bruising was significantly larger and the knot was slightly bigger, smaller than a tennis ball but larger then a golf ball. This nurse contacted the advanced practice registered nurse at this time to consult if R3 should be seen. She advised that R3 go to urgent care on this day for evaluation ..."Per R3's request daughter was not notified of transportation to urgent care. R3 stated she did not want the daughter present at the appointment. This nurse spoke with daughter on 04/17/23 about the incident". The R3 electronic progress notes revealed an entry on 04/09/23 and 04/17/23 for an effective as needed medication administration. The electronic progress notes lacked any entries prior to 04/17/23 related to a fall. The electronic progress note was on 04/20/23 for an effective as needed medication administration. R3 electronic record lacked documentation of the fall at the time of the fall, actions taken at the time of the fall and results of those actions at the time of the fall. The fall occurred on 04/12/23 and the first note made in the record was dated five days after the fall on 04/17/23.	S3261		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF AUBURN	280 E VALLEY SPRINGS DR AUBURN, KS 66402

(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
S3261	Continued From page 42 The operator failed to ensure the documentation of all incidents, symptoms, and any other indications of illness or injury including the date, time of occurrence, actions taken and results of the actions for R1 and R3.	S3261		
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 by: K.A.R. 26-41-104 (d) (3) (4) The facility reported a census of 28 residents. Based on interview the operator failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of	S3280		

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S3280	Continued From page 43 the facility's emergency management plan with employees and residents and conducting at least annually an emergency drill which included the evacuation of the residents to a secure location. Findings included: - Interview on 06/21/23 at approximately 11:00 AM with operator B during the completion of the departments "Entrance Tour Checklist", the was request made for documentation of the quarterly emergency preparedness reviews with all staff and residents, and the last annual evacuation drill. Interview on 06/22/23 at approximately 05:00 PM with operator B, Licensed Nurse C and regional vice president D, they confirmed were unable to provide documentation of the quarterly emergency preparedness training with all staff and residents. The documentation for the annual evacuation drill was not provided. The operator failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's emergency management plan with employees and residents and conducting at least annually an emergency drill which included the evacuation of the residents to a secure location.	S3280		
S3310 SS=F	26-41-207 (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	S3310		

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S3310	Continued From page 44 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 (c) Each administrator or operator shall ensure the facility ' 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: K.A.R 26-41-207 (c) The facility reported a census of 28 residents. The sample included 7 "Resident's" (R's)1, 2, 3, 4, 5, 6 and 7, and 5 newly hired employees. Based on record review and interview the operator failed to ensure the facility's compliance with the departments "Tuberculosis" (TB) guidelines for R's 2, 4, 6, 7 and for 5 of the 5 newly hired employees. Findings included: - Record review on 06/22/23 for newly hired operator B revealed she began employment on 11/22/22. The employee record lacked documentation for the required two-step TB testing within seven days of employment. Record review for newly hired "Licensed Nurse" (LN) C revealed she began employment on	S3310		

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S3310	Continued From page 45 03/08/23. The employee record lacked documentation for the required two-step TB testing within seven days of employment. Record review for newly hired "Certified Medication Aide" (CMA) MM revealed she began employment on 12/05/22. The employee record lacked documentation for the required two-step TB testing within seven days of employment. Record review for newly hired "Certified Nurse Aide" (CNA) NN revealed she began employment on 05/20/23. The employee record lacked documentation for the required two-step TB testing within seven days of employment. Record review for newly hired CMA II revealed she began employment on 09/16/22. The employee record lacked documentation for the required two-step TB testing within seven days of employment. Interview with operator B on 06/22 at 12:50 PM, she stated the nurse from the Topeka sister facility performed the TB skin test and that the Topeka nurse was looking for the paperwork. Electronic mail on 06/26/23 from operator B confirmed the nurse from Topeka was unable to find the newly hired employee's TB skin test documentation. Record review for R2 revealed an admission date of 06/03/22 with diagnoses of polymyositis with organ involvement, common variable immunodeficiency, generalized anxiety disorder, essential hypertension, glaucoma, other reduced mobility, need for assistance with personal care,	S3310		

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S3310	Continued From page 46 and type two diabetes. Review of R2 electronic immunization record revealed it lacked an entry for a two step TB test within 7 days of admission. Record review for R4 revealed an admission date of 12/12/22 with diagnoses of pain, unspecified dementia, anxiety disorder, depression, and essential hypertension. Review of R4 electronic immunization record revealed step one of the two step TB skin test was administered on 03/28/23. The electronic record lacked documentation of the second step of the two step TB skin test. Record for R6 revealed an admission date of 01/17/22 with diagnoses of acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity, saddle embolus of pulmonary artery without acute cor pulmonale, chronic idiopathic constipation, major depressive disorder, edema, peripheral vascular disease, chronic kidney disease stage three. Record review of R6 electronic clinical assessments revealed the most recent TB symptom screen was dated for 01/17/22. The record lacked an annual TB symptom screening. Record review for R7 revealed an admission date of 08/01/22 with diagnoses of iron deficiency anemia, restlessness and agitation, depression, alcohol abuse, nicotine dependence, schizoaffective disorder, chronic obstructive pulmonary disease, diverticulosis on intestine, dysphagia oropharyngeal phase, and need for	S3310		

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S3310	Continued From page 47 assistance with personal care. Record review of R7 electronic immunization record revealed step one of the two step TB skin test was administered on 03/23/23. The electronic record lacked documentation of the second step of the two step TB skin test. Interview on 06/22/23 at approximately 05:00 PM with operator B, LN C and regional vice president D, they confirmed the lack of documentation of the required two step TB skin test for R's 2, 4, 7, and the annual screening for R6. the operator failed to ensure the facility's compliance with the departments "Tuberculosis" (TB) guidelines for R's 2, 4, 6, 7 and for 5 of the 5 newly hired employees.	S3310		