STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N070007	A. BUILDING: _____ B. WING _____	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON ASSISTED LIVING LLC	629 HOLLIDAY STREET OSAGE CITY, KS 66523

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S 000	INITIAL COMMENTS The following represent the findings of a resurvey for the above named Assisted Living facility conducted on 07/18/23.	S 000		
S3085 SS=F	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 13 residents with three residents included in the sample. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed on what triggered in the "Functional Capacity Screen"	S3085		

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

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S3085	Continued From page 1 (FCS) for resident (R)101, R102 and R103. Findings included: - R101's medical record revealed the resident moved into the facility on 04/01/22. The 04/01/23 FCS identified R101 had impaired short-term memory and decision-making abilities and also triggered for falls. The 04/01/23 NSA did not address what staff were going to do to address R101's impaired short-term memory and decision-making abilities and did not address falls. The operator failed to ensure R101's NSA was fully developed to include all items that triggered on the FCS. - R102's medical record revealed she moved into the facility on 03/20/22. The 03/20/23 FCS identified R102 as having triggered for bladder incontinence and falls and had impaired memory recall and decision-making abilities. The 03/20/23 NSA did not address what staff were going to do to address R102's bladder incontinence, falls and memory recall and decision-making impairments. The operator failed to ensure R102's NSA was fully developed to include all items that triggered on the FCS.	S3085		

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S3085	Continued From page 2 - R103's medical record revealed she moved into the facility on 09/22/21. The 02/03/23 FCS identified R103 as having short-term memory and decision-making impairments. The 02/03/23 NSA did not address what staff were going to do to address R103's short-term memory and decision-making impairments. The operator failed to ensure R103's NSA was fully developed to include all items that triggered on the FCS.	S3085		
S3165 SS=F	26-41-204 (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 26-41-204(d) The facility reported a census of 13 residents with three residents included in the sample. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) identified the licensed nurse responsible for the implementation and supervision of the health care services plan for resident (R)101, R102 and R103.	S3165		

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S3165	Continued From page 3 Findings included: - R101's medical record revealed the resident moved into the facility on 04/01/22. R101's most recent NSA was completed on 04/01/23. The nurse identified as the nurse responsible for the implementation and supervision of the Health Care Service Plan (HCSP) was no longer employed at the facility and no addendum had been completed to identify the new nurse who was responsible for the implementation and supervision of the HCSP. On 07/18/23 at 05:24 PM Administrative Staff A acknowledged that resident NSAs should have been revised to indicate who the new nurse responsible for the implementation and supervision of the HCSP was. The operator failed to ensure R101's NSA was updated to identify the current licensed nurse responsible for the implementation and supervision of the health care services plan. - R102's medical record revealed the resident moved into the facility on 03/20/22. R102's most recent NSA was completed on 03/20/23. The nurse identified as the nurse responsible for the implementation and supervision of the HCSP was no longer employed at the facility and no addendum had been completed to identify the new nurse who was responsible for the implementation and supervision of the HCSP.	S3165		

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S3165	Continued From page 4 On 07/18/23 at 05:24 PM Administrative Staff A acknowledged that resident NSAs should have been revised to indicate who the new nurse responsible for the implementation and supervision of the HCSP was. The operator failed to ensure R102's NSA was updated to identify the current licensed nurse responsible for the implementation and supervision of the health care services plan. - R103's medical record revealed the resident moved into the facility on 09/22/21. R103's most recent NSA was completed on 02/03/23. The nurse identified as the nurse responsible for the implementation and supervision of the HCSP was no longer employed at the facility and no addendum had been completed to identify the new nurse who was responsible for the implementation and supervision of the HCSP. On 07/18/23 at 05:24 PM Administrative Staff A acknowledged that resident NSAs should have been revised to indicate who the new nurse responsible for the implementation and supervision of the HCSP was. The operator failed to ensure R103's NSA was updated to identify the current licensed nurse responsible for the implementation and supervision of the health care services plan.	S3165		
S3211 SS=F	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may	S3211		

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S3211	Continued From page 5 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. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 13 residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of over the counter (OTC) medications for four residents. Findings included: - Observation on 07/18/23 at 12:28 PM revealed the facility's medication cart contained the following OTC medications which were not labeled with a resident's full name: Resident (R)101: One bottle of Tylenol Extra Strength R104: One bottle of Allegra Allergy	S3211		

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S3211	Continued From page 6 R105: One bottle of Vitamin D3 R106: One bottle of Rexall Stool Softener There was also found OTC medications that did not have any information identifying which resident they belonged to include: One bottle of Equate Allergy Relief One bottle of Equate Stool Softener On 07/18/23 at 12:32 PM Administrative Staff A stated all OTC medications needed to be labelled with the full name of the resident. The operator failed to ensure all OTC medications were labeled by a pharmacist or licensed nurse with the resident's full name.	S3211		
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: KAR 26-41-105(f)(11) The facility reported a census of 13 residents.	S3261		

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The sample included three residents. Based on observation, interview and record review the operator failed to ensure two of three sampled resident records contained documentation of all incidents, actions taken and results of the action.

Findings included:

-R101's medical record revealed he moved into the facility on 04/01/22 with a diagnosis of atrial fibrillation.

The 04/01/23 "Functional Capacity Screen" (FCS) documented R101 was independent with transfers and mobility, used a wheelchair and triggered for falls.

The 04/01/23 "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCSP) did not address how staff were to address R101's falls and did not include any potential interventions in place to help prevent falls.

Review of the "Incident / Accident Reports" completed for falls experienced by R101 revealed a space in which an intervention should be documented but a possible intervention was not documented for the following dates: 01/30/23, 01/31/23, 02/22/23, 02/26/23, 03/01/23, 03/26/23, 04/08/23, 05/21/23, 05/27/23, 05/29/23 and 06/02/23.

An observation on 07/18/23 at 04:40 PM revealed R101 sat in a lift chair in his apartment. There was a wheelchair close by. After the interview, R101 independently transferred

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himself to his wheelchair and mobilized to the dining room for supper.

On 07/18/23 at 04:40 PM R101 stated his legs were just about "played out", his sense of balance was terrible, and he relied on his wheelchair to get around. R101 stated facility staff moved his wife to another apartment due to him trying to help his wife and end up falling himself. R101 stated the staff have encouraged him to use his alert button when he needed assistance.

On 07/18/23 at 03:41 PM Certified Medication Aide (CMA) B stated R101 was cognitively intact, understood instructions and was independent with transfers and mobility using a wheelchair. CMA B stated R101 had a history of falling and stated these falls were mainly associated with R101 trying to assist his wife instead of notifying staff. CMA B also stated R101 flopped into his wheelchair and staff have educated R101 to be more careful when sitting in his wheelchair by reaching back and grabbing his wheelchair. CMA B stated R101 has been educated on and will use his alert button when he needed help.

On 07/18/23 at 04:01 PM Licensed Nurse (LN) C stated R101 was cognitively intact and able to understand instructions. LN C stated R101 was independent with transfers and mobility and used a wheelchair. LN C stated R101 has had many falls and that R101's wife used to share the same apartment with him. LN C stated R101 and his wife were co-dependent with cares and R101 tried to assist his wife instead of following directions by calling for staff assistance. LN C stated R101's wife was moved to a separate

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apartment in order to help prevent falls due to his trying to help her.

On 07/18/23 at 05:24 PM Administrative Staff A stated R101 was cognitively intact and able to relate what transpired so she didn't feel there should necessarily be an intervention put into place for his falls. Administrative Staff A stated R101 felt it was a task as a husband to help his wife. Administrative Staff A stated staff first moved R101's into a different apartment but this didn't help so eventually they moved his wife to a different facility. Administrative Staff A stated there was a place on the incident report where staff could put an intervention and staff have been educated on filling out this section.

The operator failed to ensure designated staff included documentation of all incidents, action taken, and results of the action.

- R102's medical record revealed she moved into the facility on 03/20/22 with a diagnosis of type 2 diabetes mellitus.

The 03/20/23 FCS documented R102 required physical assist with toileting, supervision with transfers and mobility, used a walker and triggered for falls.

The 03/20/23 NSA/HCSP did not address how staff were to address R102's falls and did not include any potential interventions in place to help prevent falls.

Review of the "Incident / Accident Reports" completed for falls experienced by R102 revealed a space in which an intervention should

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be documented but a possible intervention was not documented for the following dates: 01/08/23 and 06/18/23.

Review of R102's medical records revealed "Nurse's Notes" documented falls on 01/08/23, 04/30/23 and 06/18/23 all related to R102 needing to use the toilet.

On observation on 07/18/23 at 04:55 PM revealed R102 sat in her recliner and there was a four-wheeled walker close by.

On 07/18/23 at 04:55 PM R102 stated she was independent with transfers and ambulation using a four-wheeled walker. R102 stated staff encouraged her to use her alert button when she needed assistance, staff watched over her closely due to her falling easily, and she was on a physical therapy program to help her improve her strength.

On 07/18/23 at 03:36 PM CMA B stated R102 was cognitively intact, was independent with transfers and ambulation but staff have encouraged R102 to use her call light when she needed to use the restroom so staff could provide stand by assistance due to R102 having had previous falls. CMA B stated R102 received physical therapy to help improve her strength.

On 07/18/23 at 03:58 PM LN C stated R102 was independent with transfers and ambulation using a walker. Stated R102 has had a few falls and interventions put into place included moving R102 to a room closer to the nurses' station and getting a different lift chair. LN C stated R102 was able to follow instructions and has been

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S3261	Continued From page 11 educated to use her call button when she needed assistance or felt "off" due to having blood sugar issues. On 07/18/23 at 05:24 PM Administrative Staff A stated R102 was cognitively intact and able to relate what transpired so she didn't feel there should necessarily be an intervention put into place for her falls. Administrative Staff A stated there was a place on the incident report where staff could put an intervention and staff have been educated on filling out this section. The operator failed to ensure designated staff included documentation of all incidents, action taken, and results of the action.	S3261		