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	N087038	A. BUILDING: _____ B. WING _____	10/18/2023

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S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure survey with complaint investigations 181399 and 181443 for the above named Assisted Living Facility conducted on 10/16,17,18/2023.	S 000		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility 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: K.A.R 26-41-201 (d) The facility reported a census of 22 residents(R). The sample included three residents and one focused record review. Based on observation, record review and interview the executive director failed to ensure designated facility staff completed two (R4 and R5) of three sampled resident's "Functional Capacity Screen" accurately to reflect their functional ability and need for assistance. Findings included: - Review of R4's medical record revealed she moved into the facility on 04/17/23 with diagnosis of dementia. R4's "Functional Capacity Screen" (FCS) dated 05/16/23 identified the resident had no cognitive	S3082		

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

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S3082	Continued From page 1	S3082		

impairment.

An interview on 10/17/23 at 11:25 AM Certified Medication Aide D reported the resident was not alert and oriented and staff had to do almost everything for her and cue her to do things.

An interview on 10/17/23 at 04:21 PM the resident said she did not what day it was or where she was living. She got frustrated and wouldn't say anything more to the surevyeor.

An interview on 10/18/23 at 09:17 AM Administrative Licensed Nurse B reported the resident would not know where to go if you told her to go to the dining room. Licensed Nurse B reviewed the FCS and said she did not know why it was a "0", it should be a "3" because she does have cognitive impairment.

The executive director failed to ensure designated staff completed R4's FCS accurately related to her cognitive impairment.

- Review of R5's medical record revealed she moved into the facility on 06/01/23 with diagnoses of hypertension and lupus.

R5's "Functional Capacity Screen" (FCS) dated 06/29/23 revealed the resident needed supervision from staff with dressing, supervision with transfers, and supervision with mobility and had some memory recall deficit.

On 10/17/23 at 08:47 AM Certified Nurse aide C pushed resident in her wheelchair back down to her appartment. Certified Nurse Aide C and Certified Nurse Aide F then positioned R5's

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S3082	Continued From page 2	S3082		

wheelchair infront of the recliner and with one staff on each side they lifeted the resident to help her stand up and get into her recliner. Certified Nurse Aide C repositioned the residents legs for comfort, got her a pillow and then staff left the resident's room.

On 10/17/23 at 08:50 AM R5 reported the staff have to help her in and out of her wheelchair and reclinerand they help her to the bathroom and with getting her showers.

On 10/17/23 at 11:23 AM Certified Medication Aide D reported the staff help her with getting dressed, help with her showers and one person can help with transfering her in and out of chairs.

On 10/17/23 at 01:07 PM Certified Nurse Aide C reported the resident could do a lot of things herself and staff mostly provide stand by assistance. Certified Nurse Aide C reported when we help transfer her we are lifting under her arms to help her stand to transfer and staff push her in the wheelchair for going to all meals and activities.

On 10/18/23 at 08:47 AM Certified Nurse Aide C reported the resident did wear ted hose and that staff put them on her in the morning and then staff took them off in the evening.

On 10/18/23 at 09:20 AM Administrative Licensed Nurse B reported the resident gets up and takes herself to the bathroom when she is in her appartment, but if staff are having to help her with transfers it would be a "2". Administrative Licensed Nurse did not think she wore ted hose anymore but if staff are putting on her ted hose

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S3082	Continued From page 3 or tubi-grips then it should have been coded a "2" and mobility should have been coded a "2" as well since staff are pushing her to meals and activities in her wheelchair. The executive director failed to ensure designated staff completed R5's FCS accurately related to her functional status for dressing, mobility, and transfers.	S3082		
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 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 22 residents. Based on observation and interview, the executive director failed to ensure all over-the-counter medications were labeled with the resident's full name. This includes the need	S3211		

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S3211	Continued From page 4 for the resident's full name to be on the original manufacturer's medication package and the medication container/tube. Findings included: - On 10/17/23 at 07:40 AM Certified Medication Aide C unlocked the medication room and the medication cart for inspection. Observations revealed the following bottles of over the counter medications had a piece of paper wrapped around it and secured with a rubberband and no resident name on the bottle: two bottles of Purxcel supplement, Immune supplement, Daily Build supplement, Prevagen, Magnesium, Occuvite, Vitamin D3, and bottle of Hair, Skin and Nails all without a residents full name on the bottle. On 10/17/23 at 08:12 AM Administrative Licensed Nurse Stated the papers were the medical providers order for the medication and did not realize it also had to have the resident's full name on the bottles. The executive director failed to ensure all over-the-counter medications included the full name of the resident they belonged to and included the name on the original manufacturer's medication package and the medication container.	S3211		
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:	S3280		

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S3280	Continued From page 5 (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: KAR 26-41-104(d)(3) The facility reported a census of 22 residents. Based on record review and interview for all residents, the executive director failed to ensure disaster and emergency preparedness by ensuring performance of quarterly reviews of the facility's emergency management plan with all residents. Findings included: - On 10/16/23 at 05:41 PM review of the resident council minutes provided by Administrative Staff A as record for reviewing the emergency management plan with residents, included the following reviews of emergency plans: 12/12/22 - 11 residents present, and reviewed emergency preparedness.	S3280		

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S3280	Continued From page 6 03/16/23 - 09 residents present, and reviewed emergencies related to flood and hurricane. 06/30/23 - 11 residents present, and reviewed emergencies related to tornado and loss of water. 09/11/23 - 08 residents present, and reviewed extreme heat and cold and loss of power. Review of the resident council minutes failed to include review of explosion, natural gas leak, and missing residents. It also revealed the facility failed to review all eight required possible emergencies with all residents every quarter. On 10/16/23 at 05:50 PM Activity Staff E reported she thought they could break it up quarterly and acknowledged she did not go around and review the plan with residents who did not attend resident council meetings. The executive director failed to ensure the facility's emergency management plan which included all eight required possible emergencies was reviewed with all residents quarterly.	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 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	S3310		

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S3310	Continued From page 7 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: KAR 26-41-207(c) The facility reported a census of 22 residents (R). The sample included three residents and review of five newly hired employees record. Based on interview and record review the executive director 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 one of five newly hired employees. Findings included: - Review of newly hired Certified Medication Aide (CMA) C's employee file revealed she was hired on 08/10/23. CMA C's record included a TB symptom screen completed 08/11/23 but did not include TB skin testing completed within seven days of employment. Her record did have one prior TB skin test completed on 12/1/22 that was negative but was also more than six months prior to hire date. On 10/17/23 at 12:27 PM Administrative Staff A reported the nurse gives new employees their first TB skin test within a week of hire and then another one about a week later. Administrative staff though if they had proof of a negative TB	S3310		

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S3310	Continued From page 8 test within one year, they did not have to give another one. The department's June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented "Each new employee shall have an initial TB symptom screen. . . within seven days of employment. . . Each new employee shall receive a two-step TST. . . within seven days of residency or employment unless one of the following conditions is met ... b. The new resident or employee provide satisfactory documentation of receiving the two-step TST or AGRA within 6 months prior to residency or employment that read not positive." The executive director failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		
S3420 SS=E	28-39-256 MECHANICAL REQUIREMENTS (c) Mechanical requirements. (1) Heating, air conditioning, and ventilating systems. (A) The system shall be designed to maintain a year-round indoor temperature range of 70oF or 21oC to 85oF or 26oC. (B) Each apartment or individual living unit shall allow the resident to control the temperature. (2) Plumbing and piping systems.	S3420		

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S3420	Continued From page 9 (A) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (B) Water distribution systems shall be arranged to provide hot water at outlets at all times. The temperature of hot water shall range between 98oF and 120oF at bathing facilities, sinks, and lavatories in resident use areas. (3) Electrical requirements. (A) All spaces occupied by persons or machinery and equipment within the buildings, approaches to buildings, and parking lots shall have adequate lighting. (B) Minimum lighting intensity levels shall be as required in Table 1. (C) Each corridor and stairway shall remain lighted at all times. (D) Each light in resident use areas shall be equipped with shades, globes, grids, or glass panels. This REQUIREMENT is not met as evidenced by: KAR 28-39-256(c)(2)(B) The facility reported a census of 22 residents. Based on observation, and interview the facility failed to ensure the temperature of hot water in the resident restroom by the dining room ranged between 98 degrees Fahrenheit (F) and 120 degrees F to ensure residents did not acquire	S3420		

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S3420	Continued From page 10 injury from exposer to hot water temperatures out of guideline ranges. Findings included: - During initial tour on 10/16/23 at 04:50 PM the restroom by the dining room was unlocked and surveyor was unable to hold her hand under the hot water. Surveyor then checked the water with the thermometer, and it started at 117 F and then went up to 131 degrees F, held there for a couple of seconds and then went back down to 110 degrees F. Surveyor checked it again at 04:53 PM and it started at 113 degrees F and went up to 132.8 degrees F before it started to go back down. On 10/16/17/23 at 04:57 PM Administrative Staff A came to the restroom and as the thermometer started to go above 120 degrees F she stated the hot water tanks are on the other side of the restroom wall and so the hot water goes to this sink first, but the mixer valve is supposed to bring it right back down within range. On 10/17/23 at 04:08 PM surveyor spoke with Administrative Staff A and explained that the hot water in the resident communal rest room is still too hot, and she needed to have someone come and look at the mixer valve for resident safety. On 10/18/23 at 08:58 AM surveyor checked the hot water in the "resident restroom" by the dining room and at 16 seconds it read 122 degrees F, at 23 seconds it read 128 degrees F, and at 30 seconds started to go back down within range. As surveyor came out of the restroom, Certified Nurse Aide C told the	S3420		

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S3420	Continued From page 11 surveyor this restroom was for resident use and there was another restroom for visitors. On 10/18/23 at 09:54 AM Administrative Staff A stated the company came out last night and adjusted the mixer valve on the hot water heater and told her it was at 105 degrees F now. Surveyor explained that when the hot water is turned on it will initially go up to 128 degrees F before it comes down within range which is still a risk for residents to get skin injuries from too hot of water. The operator failed to ensure hot water temperatures were between 98 degrees F and 120 degrees F in resident use areas.	S3420		