STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N030004	A. BUILDING: _____ B. WING _____	11/07/2023

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WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

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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 11/06/23 and 11/07/23.	S 000		
S3085 SS=E	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 18 residents with three residents included in the sample. Based on interview, and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed on what triggered in the "Functional Capacity	S3085		

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

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S3085	Continued From page 1	S3085		

Screen" (FCS) for resident (R)101, R102 and R103.

Findings included:

- R101's medical record revealed the resident moved into the facility on 01/24/22.

The 12/15/22 FCS identified R101 required physical assistance with management of treatments and also triggered for falls and impaired hearing.

The 12/15/22 NSA did not address what staff were going to do to address R101's need for physical assistance with management of treatments, falls and hearing impairment.

On 11/07/23 at 11:39 PM Administrative Staff A acknowledged R101's NSA did not address management of treatments, falls, or impaired hearing.

The undated "Assisted Living Negotiated Service Agreement" policy documented, "The Administrator ...of this assisted living facility ...will ensure the development of a written negotiated services agreement for each resident residing in this facility, based on the resident's Functional Capacity Screen ...A negotiated service agreement will provide the following information: A description of the services the resident will receive."

The administrator failed to ensure R101's NSA was fully developed to include all items that triggered on the FCS.

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S3085	Continued From page 2 - R102's medical record revealed she moved into the facility on 06/16/21. The 07/13/23 FCS identified R102 as having triggered for falls. The 07/13/23 NSA did not address what staff were going to do to address R102's trigger for falls. On 11/07/23 at 11:40 AM Administrative Staff A acknowledged R102's NSA did not address her trigger for falls. The undated "Assisted Living Negotiated Service Agreement" policy documented, "The Administrator ...of this assisted living facility ...will ensure the development of a written negotiated services agreement for each resident residing in this facility, based on the resident's Functional Capacity Screen ...A negotiated service agreement will provide the following information: A description of the services the resident will receive." The administrator failed to ensure R102's NSA was fully developed to include all items that triggered on the FCS. - R103's medical record revealed she moved into the facility on 10/23/23. The 10/23/23 FCS identified R103 required physical assistance with management of treatments and triggered for falls. The 10/23/23 NSA did not address what staff	S3085		

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S3085	Continued From page 3 were going to do to address R103's need for physical assistance with management of treatments and falls. On 11/07/23 at 09:42 AM Administrative Staff A acknowledged R103's NSA did not address management of treatments and her trigger for falls. The undated "Assisted Living Negotiated Service Agreement" policy documented, "The Administrator ...of this assisted living facility ...will ensure the development of a written negotiated services agreement for each resident residing in this facility, based on the resident's Functional Capacity Screen ...A negotiated service agreement will provide the following information: A description of the services the resident will receive." The administrator failed to ensure R103's NSA was fully developed to include all items that triggered on the FCS.	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:	S3101		

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S3101	Continued From page 4 KAR 26-41-202(h) The facility reported a census of 18 residents. The sample included three residents. Based on interview, and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) for resident (R)101, R102 and R103 was signed by all individuals involved in the development of the NSA to include the nurse responsible for the development of the NSA. Findings included: - R101's medical record revealed the resident moved into the facility on 01/24/22. The 12/15/22 NSA documented signatures for the resident and the administrator but was not signed by the nurse who developed the NSA. On 11/07/23 at 11:39 AM Administrative Staff A acknowledged R101's NSA was not signed by the nurse who developed it. The undated "Assisted Living Negotiated Service Agreement" policy documented, "The individual involved in the development of the negotiated service agreement will sign the agreement." The administrator failed to ensure R101's NSA was signed by all individuals involved in the development of the NSA. - R102's medical record revealed the resident moved into the facility on 06/16/21. The 07/13/23 NSA documented signatures for	S3101		

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S3101	Continued From page 5 the resident and the administrator but was not signed by the nurse who developed the NSA. On 11/07/23 at 11:39 AM Administrative Staff A acknowledged R102's NSA was not signed by the nurse who developed it. The undated "Assisted Living Negotiated Service Agreement" policy documented, "The individual involved in the development of the negotiated service agreement will sign the agreement." The administrator failed to ensure R102's NSA was signed by all individuals involved in the development of the NSA. - R103's medical record revealed the resident moved into the facility on 10/23/23. The 10/23/23 NSA documented signatures for the resident and the administrator but was not signed by the nurse who developed the NSA. On 11/07/23 at 11:39 AM Administrative Staff A acknowledged R103's NSA was not signed by the nurse who developed it. The undated "Assisted Living Negotiated Service Agreement" policy documented, "The individual involved in the development of the negotiated service agreement will sign the agreement." The administrator failed to ensure R103's NSA was signed by all individuals involved in the development of the NSA.	S3101		
S3155 SS=D	26-41-204 (a) Health Care Services	S3155		

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S3155	Continued From page 6 . (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. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 18 residents. The sample included three residents. Based on observation, interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for one of three sampled residents evidenced by the failure to complete and document an assessment for the purpose to use bed rails, ability to use bed rails safely without risk of entrapment, and to confirm the bed rails were not a restraint for resident (R)101. Findings included: - R101's medical record revealed the resident moved into the facility on 01/24/22. The 12/15/22 "Functional Capacity Screen" (FCS) documented R101 was independent with	S3155		

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S3155	Continued From page 7 transfers and walking/mobility. The 12/15/22 "Negotiated Service Agreement" (NSA) did not document R101 used a bed assist device. Review of R101's medical records failed to locate an assessment for the use of a bed assist device. An observation on 11/07/23 at 10:42 AM revealed there was a u-shaped bed assist device attached on the left-hand side of R101's bed. On 11/07/23 at 11:39 AM Administrative Staff A stated she did not think a "bed rail" assessment was completed for R101's use of a bed assist device. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for R101 regarding the use of a bed assistive device.	S3155		
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.	S3186		

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S3186	Continued From page 8 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(b) The facility reported a census of 18 residents. The sample included three residents. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for resident (R)102 identified the responsible person for administration and management of selected medications. Findings included: -R102's medical record revealed she moved into the facility on 06/16/21. The 07/13/23 "Functional Capacity Screen" (FCS) documented R102 required supervision with management of medications. The 07/13/23 NSA documented both staff administered medications and R104 self-administered medications. The NSA did not identify select medications for administration by the facility staff. The 07/13/23 "Self-Administration of Medication-ALF" assessment documented R102 self-administered, "all medications except advair, eye drops, lyrica, vrylar, Nystatin, Topamax, Vibramycin, and tramadol." On 11/07/23 at 10:50 AM R102 stated she	S3186		

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S3186	Continued From page 9 administered her own medications, but staff also administered some medications. On 11/07/23 at 11:01 AM Certified Medication Aide (CMA) A stated she administered some of the resident's medications, but the resident self-administered some medications. On 11/07/23 at 11:43 AM Administrative Nurse C stated she expected the NSA to identify which selected medications the facility administered for the resident and acknowledged R102's NSA did not address this. The undated, "Assisted Living Negotiated Service Agreement" policy documented, "The Administrator ...Administrative Nurse will ensure the development of the ...negotiated service agreement ...and will include ...Medication management and/or assistance required." The administrator failed to ensure R104's NSA identified who was responsible for administration and management of selected medications.	S3186		
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 10 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 18 residents. Based on observation and interview the administrator 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 11/06/23 at 01:38 PM revealed the facility's medication room contained the following OTC medications which were not labeled with a resident's full name: Resident (R)104: One bottle of Spring Valley Vitamin C 500 milligrams (mg.) R105: One unopened box of Bausch and Lomb PreserVision AREDS2 plus multivitamin R102: One Wixela (fluticasone propionate and salmeterol) inhaler Two 20 milliliter spray bottles of Avenova	S3211		

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S3211	Continued From page 11 hypochlorous acid spray solution R106: One bottle of Bausch and Lomb PreserVision AREDS2 One bottle of Vicks ZzzQuil Nighttime sleep-aid On 11/06/23 at 01:38 PM Certified Medication Aide (CMA) B stated if there was an OTC medication brought in, she would check the Medication Administration Record to see if there was an order for it and then would call the director of nursing to verify the medication and then would put the opened date on it. On 11/07/23 at 12:26 PM Administrative Nurse C stated when OTC medications were brought to the facility, medications should first go to the nurse for review and then labeled with the resident's full name before they are placed in the medication room. The undated "Medication Labeling and Storage" policy documented, "Nonprescription medications not labeled by the pharmacy are kept in the manufacturer's original container and identified with the resident's name." The administrator failed to ensure all OTC medications were labeled by a pharmacist or licensed nurse with the resident's full name.	S3211		
S3270 SS=F	26-41-104 (b) Written Emergency Plan (b) Each administrator or operator shall ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including the	S3270		

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S3270	Continued From page 12 following: (1) Fire; (2) flood; (3) severe weather; (4) tornado; (5) explosion; (6) natural gas leak; (7) lack of electrical or water service; (8) missing residents; and (9) any other potential emergency situations. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(b)(2)(5)(6)(7) The facility reported a census of 18 residents. Based on record review and interview for all residents and all facility employees, the operator failed to ensure the disaster and emergency plan include all required items as it failed to include flood, explosion, natural gas leak, and lack of water/electricity. Findings included: - On 11/07/23 review of documentation of the emergency management plan revealed it did not include information concerning flood, explosion, natural gas leak, and lack of water/electricity. On 11/07/23 at 11:30 AM Administrative Staff A acknowledged that all eight required topics were not included in the emergency management plan notebook.	S3270		

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S3270	Continued From page 13 The administrator failed to ensure the emergency management plan included all the required items.	S3270		
S3285 SS=F	26-41-104 (e) Emergency Plan Available (e) Each administrator or operator shall make the emergency management plan available to the staff, residents, and visitors. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(e) The facility reported a census of 18 residents. Based on observation and interview the administrator failed to ensure the emergency management plan was available to the staff, residents, and visitors. Findings included: - On 11/07/23 at 11:10 AM the emergency management plan was found in a cabinet located in the locked medication room. On 11/07/23 at 11:30 AM Administrative Staff A stated the emergency management plan should not be located in a locked room but should be accessible to everyone. The administrator failed to the emergency management plan was accessible to staff, residents, and visitors.	S3285		

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S3299	Continued From page 14	S3299		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility had a census of 18 residents. All 18 residents ate food prepared in the same kitchen. The administrator failed to ensure food items were stored under safe and sanitary conditions by the failure to food items not stored in their original packaging was dated according to food safety guidelines. Findings included: - Observation on 11/06/23 at 01:59 PM revealed the freezer located in the dry goods storage room had packages of hash browns, breakfast sausages and hamburger patties in Ziplock bags that were not dated or labeled. On 11/06/23 at 02:06 PM Dietary Staff D stated all items placed in storage bags in the fridge/freezer should be dated. The undated "Food Preparation and Handling Policy" documented, "The facility will store ...food	S3299		

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S3299	Continued From page 15 in accordance with professional standards for food service safety ...Food items will be received, checked, dated with receiving date and "use-by" date, and stored properly as soon as delivery is completed." The administrator failed to ensure food items were stored under safe and sanitary conditions.	S3299		