STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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 for the above named facility conducted on 04/29/24 and 04/30/24.	S 000		
S5095 SS=E	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-201 (d) The facility reported a census of 5 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on interview and record review the operator failed to ensure that each resident "Functional Capacity Screen" (FCS) form accurately reflected R1 and R3 at the time of the screening when determining R1 and R3's functional capacity related to the management of medical treatments. Findings included: - Record review on 04/29/24 of the facility provided resident roster revealed R1 and R3 gave their own medications. Interview on 04/29/24 at approximately 12:25 PM with Operator A confirmed R1 and R3 kept an	S5095		

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

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S5095	Continued From page 1	S5095		

"Over the Counter" (OTC) topical treatment in their rooms, and they applied the topical OTC themselves.

- Record review for R1 revealed an admission date of 05/15/23 with diagnoses of dementia, hypertension, diverticulitis, and irritable bowel syndrome.

Review of R1's FCS dated 05/03/23 revealed R1 required supervision with bathing, dressing, transferring, and walking. She lacked the ability to manage her own medications and medical treatments, was occasionally incontinent, and her cognition was intact. She was able to make herself understood and she understood others. She was marked with falls, impaired vision, and impaired hearing. She used a walker mobility device.

Review of R1's NSA dated 05/15/23 identified the facility would provide the following health service:
management of her medications and assist with bathing.

R1's NSA did not identify the topical OTC kept in her room that she independently self-applied.

Review of R1's "Health Service Plan" (HSP) revealed in the "Skin Needs" section handwritten in the blank was "may keep topicals at bedside and apply independently."

Review of R1's "Medication Administration Record" (MAR) for 04/24 revealed the following orders:

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S5095	Continued From page 2 "May Keep Topicals (Overt the Counter) at bedside and self-administer independently." - Record review for R3 revealed an admission date of 09/19/22 with diagnoses of chronic respiratory failure, tachycardia, and frailty. Review of R3's "Functional Capacity Screen" dated 10/19/23 revealed she required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and she was independent with eating. She lacked the ability to manage her own mediations/treatments and was usually continent. She had impaired memory recall and was able to make herself understood and she understood others. She was marked with falls and impaired hearing. She used a walker mobility device. Review of R3's NSA dated 01/19/22 instructed facility staff to provide the following health services; management of her medications/treatments, bathing as needed, and one staff member to assist her to the bathroom as needed. R3's NSA did not identify the OTC topical that she independently self-applied. Review of R3's HSP under the section titled "Medications" was handwritten in the blank "See MAR". Review of R3's MAR revealed the following: Bio freeze Gel 4% apply topically to affected area of left shoulder and neck as needed.	S5095		

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S5095	Continued From page 3 Interview on 04/30/24 at approximately 02:00PM with Operator A confirmed R1 and R3 keep the Bio freeze Gel in their rooms. She continued to state that R1 self-administers the treatment, and R3's hospice nurse will apply the Bio freeze when R3 receives her shower. She confirmed the FCS was not accurate and that R1 and R3 could safely and accurately manage the medical treatment of their topical OTC. The operator failed to ensure that each resident FCS form accurately reflected R1 and R3 at the time of the screening, when determining R1 and R3's functional capacity related to the management of medical treatments.	S5095		
S5116 SS=D	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-202 (d) (1)	S5116		

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S5116	Continued From page 4 The facility reported a census of 5 residents. The sample included 3 "Residents'" (R)'s. Based on record review and interview the operator failed to ensure R3's "Negotiated Service Agreement" (NSA) was reviewed, and if necessary, revised at least once every 365 days. Findings included: - Record review for R3 revealed an admission date of 09/19/22 with diagnoses of chronic respiratory failure, tachycardia, and frailty. Review of R3's "Functional Capacity Screen" (FCS) dated 10/19/23 revealed she required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and she was independent with eating. She lacked the ability to manage her own mediations/treatments and was usually continent. She had impaired memory recall and was able to make herself understood and she understood others. She was marked with falls and impaired hearing. She used a walker mobility device. Review of R3's NSA dated 01/19/22 instructed facility staff to provide the following health services; management of her medications/treatments, bathing as needed, and one staff member to assist her to the bathroom as needed. Interview on 04/30/24 at approximately 02:00 PM with Operator A confirmed R3 did not have a more current NSA and the one dated 01/19/22 was greater than 365 days old.	S5116		

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S5116	Continued From page 5 The operator failed to ensure R3's NSA was reviewed, and if necessary, revised at least once every 365 days.	S5116		
S5171 SS=E	26-42-204 (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. 26-42-204 (i) The facility reported a census of 5 residents. The sample included 3 "Residents'" (R)1, 2, and 3. Based on observation, record review and interview, the operator failed to provide healthcare services for R1 and R2 in accordance with professional standards of practice when Operator A failed to conduct an assessment for R1 and R2 bed assist devices to ensure the devices posed no risk for entrapment, confirmed the devices were not a restraint, R1 and R2's ability to safely use the bed assist device. and ensure that R1's bed assist device was securely attached to the bed. The operator further failed to ensure the bed assist devices were listed on R1 and R2's "Functional Capacity Screens'" (FCS)'s in the comment section if R1 and R2 used the bed assist devices to assist with transferring, and provide a description of the bed assist device, the purpose of the bed assist device, any special instructions on use and monitoring of the bed assist device in R1 and R2's "Negotiated Service Agreements'" (NSA)'s.	S5171		

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S5171	Continued From page 6 Findings included: - Record review for R1 revealed an admission date of 05/15/23 with diagnoses of dementia, hypertension, diverticulitis, and irritable bowel syndrome. Review of R1's FCS dated 05/03/23 revealed R1 required supervision with bathing, dressing, transferring, and walking. She lacked the ability to manage her own medications and medical treatments, was occasionally incontinent, and her cognition was intact. She was able to make herself understood and she understood others. She was marked with falls, impaired vision, and impaired hearing. She used a walker mobility device. R1's FCS dated 05/03/23 lacked the bed assist device listed in the comments section. Review of R1's NSA dated 05/15/23 identified the facility would provide the following health service: management of her medications and assist with bathing. R1's NSA lacked documentation of a description of the bed assist device, the purpose of the bed assist device, any special instructions on use and monitoring of the bed assist device. Review of R1's "Health Service Plan" (HSP) instructed facility staff to assist R1 with her showers every other day and supervise her when ambulating for safety.	S5171		

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S5171	Continued From page 7 Observation on 04/20/24 at approximately 01:15 PM R1 was laying on her bed, the left side of the twin bed was against the southeast corner of the room. The head of the bed was in the southeast corner and the foot of the bed was pointed towards the west side of the room. The left side of the bed was against the wall. On the right side of the upper portion of the bed an inverted "U" shaped bed assist device was slid under the mattress with two legs touching the floor. The device measured 34 inches in height with adjustable legs, and 13.5 inches in width. There was a cloth pocket covering the open space of the inverted "U" shape. The device freely pulled away from the bed when pulled on. R1 reached for the device to assist her to a sitting position during the observation. The bed assist device was not securely attached to R1's bed. - Record review for R2 revealed an admission date of 01/23/23 with diagnoses of coronary artery disease, chronic kidney disease, orthostatic hypotension, short term memory loss and presence of a cardiac pacemaker. Review of R2's FCS dated 01/10/24 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, walking, and supervision with eating. She lacked the ability to manage her own medication and medical treatments. She was frequently incontinent and had impaired short-term memory and impaired decision making. She was usually able to make herself understood and she usually understood others. She was marked with falls, impaired hearing, wandering, and impaired decision	S5171		

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S5171	Continued From page 8	S5171		

making. She used a walker mobility device.

R2's FCS dated 01/10/24 lacked the bed assist device listed in the comments section.

Review of R2's NSA dated 01/10/24 identified the facility would provide the following health services; management of her medications, bathing two times per week, dressing, toileting, and stand by assistance with ambulation.

R2's NSA lacked documentation of a description of the bed assist device, the purpose of the bed assist device, any special instructions on use and monitoring of the bed assist device.

Review of R2's HSP instructed facility staff to physically assist R2 with a shower two times a week, one person assist to the toilet every two hours and as needed, one person to assist with ambulation due to history of falls, and frequently monitor R2.

Observation on 04/30/24 at approximately 01:30 PM revealed R2 sitting on the edge of her bed. The bed sat against the northwest corner of her room. The head of the bed was in the northwest corner and the foot of the bed was pointed towards the southeast corner. The left side of the bed sat against the wall. On the upper portion of the right side of the bed slid under the mattress and was anchored between the bedframe and the mattress frame, was an inverted "U" shaped device which measured eighteen inches in width and 16 inches in height. There was a cloth pouch covering the eighteen-inch opening. R2 did not grasp or use the device during the observation.

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S5171	Continued From page 9 Interview on 04/20/24 at approximately 02:00 PM with Operator A confirmed R1 and R2's medical records lacked documentation of an assessment being performed ensuring the bed assist devices were not a risk for entrapment, confirmed R1 and R2's ability to safely use the devices, confirmed the devices were not a restraint, and confirmed R1's device was attached securely to the bed. She further confirmed the FCS's and NSA's for R1 and R2 lacked documentation on the FCS in the comments section if the devices assisted with transferring, and the NSA's lacked documentation providing a description of the bed assist devices, the purpose of the bed assist devices, any special instructions on use and monitoring of the bed assist devices. The FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended the following: Complete an assessment of the resident to confirm that the device is not a restraint. Complete an assessment of the resident to determine the purpose of the device and the resident's ability to safely use the device and document the findings in the resident's record. Complete an assessment of the device using the recommendations in the FDA guidance to ensure the device is securely attached to the bed or bedframe and poses no risk for entrapment and document the findings in the resident record. If the purpose of the device is to assist the resident with transfers, the FCS should	S5171		

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S5171	Continued From page 10 document the resident's functional capacity based on the use of the device and should be listed in the comments section. Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA. Document periodic reassessments of the resident's use of the device and their ability to use it safely and reassessment of the safety of the device in the resident's record. The operator failed to provide healthcare services for R1 and R2 in accordance with professional standards of practice when Operator A failed to conduct an assessment for R1 and R2 bed assist devices to ensure the devices posed no risk for entrapment, confirmed the devices were not a restraint, R1 and R2's ability to safely use the bed assist device. and ensure that R1's bed assist device was securely attached to the bed. The operator further failed to ensure the bed assist devices were listed on R1 and R2's FCS's in the comment section if R1 and R2 used the bed assist devices to assist with transferring, and provide a description of the bed assist device, the purpose of the bed assist device, any special instructions on use and monitoring of the bed assist device in R1 and R2's NSA's.	S5171		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following:	S5215		

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S5215	Continued From page 11 (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-104 (d) (3) The facility reported a census of 5 residents. Based on record review and interview, the operator failed to ensure a quarterly review of the facility's emergency management plan with employees and residents. Findings included: - Record review of the facility "Fire Drill" book revealed a staff sign in sheet for an evacuation drill with emergency preparedness training on 11/16/22. Review of the facility "Inservice" book revealed a staff sign in sheet for training on emergency preparedness dated 04/03/24. The Interview on 04/30/24 at approximately 02:00PM with Operator A confirmed the facility Emergency Preparedness Training lacked documentation of the residents reviewing the facility's Emergency	S5215		

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S5215	Continued From page 12 Management Plan at least quarterly, and she further confirmed the records lacked documentation for all four quarters of the required quarterly training for the year of 2022. The operator failed to ensure a quarterly review of the facility's emergency management plan with employees and residents.	S5215		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-207 (c) The facility reported a census of 5 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3, and 5 newly hired employees. Based on record review and interview the operator failed to ensure the home's compliance with the department's "Tuberculosis" (TB) guidelines for	S5230		

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S5230	Continued From page 13 adult care homes adopted by reference in K.A.R. 26-39 105 for R1, R2, R3, newly hired "Certified Nurse Aide" (CNA) B, and newly hired "Certified Medication Aide" (CMA) C. Findings included: - Record review on 04/29/24 for CNA B revealed she began employment on 04/05/24. The employee record lacked documentation of a TB test being administered to CNA B within 7 days of employment. Record review for CMA C revealed she began employment on 10/17/23. The employee file contained a document titled "TB Testing Record". The record revealed the first step of the required two step test was administered on 11/10/23 and read negative on 11/12/23, and the required second step was implanted on 11/27/23 and read negative on 11/30/23. CMA C received the first step of the required two step TB test twenty-six days after she started employment. - Record review for R1 revealed an admission date of 05/15/23 with diagnoses of dementia, hypertension, diverticulitis, and irritable bowel syndrome. Review of R1's medical record revealed a document titled "TB Testing Record" and revealed the first step of the required two step test was administered on 06/12/23 and read negative on 06/14/23, and the required second step was administered on 07/19/23 and read	S5230		

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S5230	Continued From page 14 negative on 07/21/23. R1 received the first step of the required two step TB test twenty-eight days after her admission to the home. The required second step was administered thirty-five days after the completed first step. - Record review for R2 revealed an admission date of 01/23/23 with diagnoses of coronary artery disease, chronic kidney disease, orthostatic hypotension, short term memory loss and presence of a cardiac pacemaker. Review of R2's medical record revealed a document titled "TB Testing Record" and revealed the first step of the required two step test was administered on 02/15/23 and read negative on 02/17/23, and the required second step was administered on 06/12/23 and read negative on 06/14/23. R2 received the first step of the required two step TB test twenty-three days after her admission to the home. The required second step was administered one hundred and fifteen days after the completed first step. - Record review for R3 revealed an admission date of 09/19/22 with diagnoses of chronic respiratory failure, tachycardia, and frailty. Review of R3's medical record revealed a document titled "TB Testing Record" and revealed the first step of the required two step test was administered on 10/31/22 and read	S5230		

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negative on 11/03/22, and the required second step was administered on 02/06/23 and read negative on 02/09/23. R3's medical record lacked the annual TB screening questionnaire.

R3 received the first step of the required two step TB test forty-two days after her admission to the home. The required second step was administered ninety-five days after the completed first step.

Review of the facility document titled "TB Testing Record" revealed the following typed at the top of the document: " As required under K.A.R. 28-39-249 (c) (d), K.A.R. 28-39-161 (b) (3), K.A.R. 28-39-253 (b) (7), K.A.R. 28-39-435 (d), for all employees in adult care home, a health screening shall be performed not later than 7 days after employment and Tuberculosis skin testing in accordance with "CDC" (Centers of Disease Control) recommendations to reasonably assure that the employee is free from any other communicable diseases or skin infections".

Interview on 04/30/24 at approximately 02:00 PM with Operator A confirmed the following;
CNA B's record lacked documentation for the required two step TB test within one to seven days of employment.
CMA C's required TB skin test was administered twenty-six days after she began employment.
R1's first step was administered twenty-eight days after her admission to the home and, R1's second step was administered thirty-five days after the completion of her first step.
R2's first step was administered twenty-three days after her admission to the home and, R2's

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second step was administered one hundred fifteen days after the completion of her first step. R3's first step was administered forty-two days after her admission to the home and, 3's second step was administered ninety-five days after the completion of her first step, and further confirmed R3 medical record lacked the required annual "TB Symptom Screen".

Review of the "Kansas Tuberculosis Guidelines for Adult Care Homes" dated 06/13 revealed the following:

Under section I. "New Resident and New Employee initial Tuberculosis System Screen and TB Infection Testing" B. "Infection Testing" 1. Each new resident and new employee shall receive a two-step TB or "IGRA" (Interferon-Gamma Release Assays) for Mycobacterium tuberculosis within seven days of residency or employment.

Under section II. "Resident and Employee Annual Tuberculosis Symptom Screen Review and Tuberculosis Infection Testing." A. "Symptom Screen" "Each resident and employee shall have an annual TB symptom screen that includes the components of the Tuberculosis Symptom Screen Review Questionnaire."

Under section IV. "Procedure for Tuberculosis Infection Testing" A. "Tuberculosis Skin Test (TST)" 1. The first TST shell be read within 48 to 72 hours of its administration. If the first test is read as not positive, a second TST shall be administered within one to three weeks.

The operator failed to ensure the home's

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S5230	Continued From page 17 compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39 105 for R1, R2, R3, CNA B, and CMA C.	S5230		
S5257 SS=F	26-42-102 (c) Staff Qualifications RN available (c) A registered professional nurse shall be available to provide supervision to licensed practical nurses, pursuant to K.S.A. 65-1113 and amendments thereto. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-102 (c) The facility reported a census of 5 residents. Based on interview the operator failed to ensure a "Registered" professional Nurse (RN) was available to provide supervision to "Licensed Practical Nurses" (LPN)'s, pursuant to K.S.A. 65-1113 and amendments thereto. Findings included: - Interview on 04/29/24 at approximately 12:30PM with Operator A confirmed the facility RN walked out and they have been trying to replace her. At this time the facility does not have an RN to provide supervision to the LPN's, Operator A continued to state that the facility LPN's call the primary care providers for all issues/orders at this time. The operator failed to ensure a "Registered" professional Nurse (RN) was available to provide	S5257		

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S5257	Continued From page 18 supervision to "Licensed Practical Nurses" (LPN)'s, pursuant to K.S.A. 65-1113 and amendments thereto.	S5257		
S5265 SS=E	26-42-205 (a) (1) Medication Self Administration Assessment (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-205 (a) The facility reported a census of 5 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on interview and record review the operator failed to ensure a "Licensed Nurse" (LN) performed an assessment and determined that R1 and R3 could safely and accurately	S5265		

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S5265	Continued From page 19 self-administer an "Over the Counter" (OTC) medical treatment when they were marked as "unable to perform" on their "Functional Capacity Screen" (FCS). Findings included: - Record review on 04/29/24 of the facility provided resident roster revealed R1 and R3 gave their own medications. Interview on 04/29/24 at approximately 12:25 PM with Operator A confirmed R1 and R3 kept an OTC topical treatment in their rooms, and they applied the topical OTC themselves. - Record review for R1 revealed an admission date of 05/15/23 with diagnoses of dementia, hypertension, diverticulitis, and irritable bowel syndrome. Review of R1's FCS dated 05/03/23 revealed R1 required supervision with bathing, dressing, transferring, and walking. She lacked the ability to manage her own medications and medical treatments, was occasionally incontinent, and her cognition was intact. She was able to make herself understood and she understood others. She was marked with falls, impaired vision, and impaired hearing. She used a walker mobility device. Review of R1's NSA dated 05/15/23 identified the facility would provide the following health service: management of her medications and assist with bathing.	S5265		

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S5265	Continued From page 20 R1's NSA did not identify the topical OTC kept in her room that she self-applied. Review of R1's "Health Service Plan" (HSP) revealed in the "Skin Needs" section handwritten in the blank was "may keep topicals at bedside and apply independently." Review of R1's "Medication Administration Record" (MAR) for 04/24 revealed the following orders: "May Keep Topicals (Overt the Counter) at bedside and self-administer independently." - Record review for R3 revealed an admission date of 09/19/22 with diagnoses of chronic respiratory failure, tachycardia, and frailty. Review of R3's "Functional Capacity Screen" dated 10/19/23 revealed she required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and she was independent with eating. She lacked the ability to manage her own mediations/treatments and was usually continent. She had impaired memory recall and was able to make herself understood and she understood others. She was marked with falls and impaired hearing. She used a walker mobility device. Review of R3's NSA dated 01/19/22 instructed facility staff to provide the following health services; management of her medications/treatments, bathing as needed, and one staff member to assist her to the bathroom as needed.	S5265		

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S5265	Continued From page 21 Review of R3's HSP under the section titled "Medications" was handwritten in the blank "See MAR". Review of R3's MAR revealed the following: Bio freeze Gel 4% apply topically to affected area of left shoulder and neck as needed. Interview on 04/30/24 at approximately 02:00PM with Operator A confirmed R1 and R3 keep the Bio freeze Gel in their rooms. She continued to state that R1 self-administers the treatment, and R3 keeps the topical in her room and R3 will "give it to the hospice nurse" when R3 receives her shower from the hospice nurse. She continued to confirm that the medical records for R1 and R3 lacked an assessment showing that they could safely and accurately self-administer an OTC medical treatment. The operator failed to ensure a LN performed an assessment and determined that R1 and R3 could safely and accurately self-administer an OTC medical treatment when they were marked as "unable to perform" on their FCS.	S5265		
S5286 SS=E	26-42-205 (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.	S5286		

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This REQUIREMENT is not met as evidenced by:
K.A.R. 26-42-205 (b)

The facility reported a census of 5 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreements'" for R's 1 and 3 identified who was responsible for the management of selected "Over The Counter" (OTC) topical medications.

Findings included:

Record review on 04/29/24 of the facility provided resident roster revealed R1 and R3 gave their own medications.

Interview on 04/29/24 at approximately 12:25 PM with Operator A confirmed R1 and R3 kept an "Over the Counter" (OTC) topical treatment in their rooms, and they applied the topical OTC themselves.

Record review for R1 revealed an admission date of 05/15/23 with diagnoses of dementia, hypertension, diverticulitis, and irritable bowel syndrome.

Review of R1's FCS dated 05/03/23 revealed R1 required supervision with bathing, dressing, transferring, and walking. She lacked the ability to manage her own medications and medical treatments, was occasionally incontinent, and her cognition was intact. She was able to make

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herself understood and she understood others. She was marked with falls, impaired vision, and impaired hearing. She used a walker mobility device.

Review of R1's NSA dated 05/15/23 identified the facility would provide the following health service:
management of her medications and assist with bathing.

R1's NSA did not identify the topical OTC kept in her room that she self-applied.

Review of R1's "Health Service Plan" (HSP) revealed in the "Skin Needs" section handwritten in the blank was "may keep topicals at bedside and apply independently."

Review of R1's "Medication Administration Record" (MAR) for 04/24 revealed the following orders:

"May Keep Topicals (Overt the Counter) at bedside and self-administer independently."

- Record review for R3 revealed an admission date of 09/19/22 with diagnoses of chronic respiratory failure, tachycardia, and frailty.

Review of R3's "Functional Capacity Screen" dated 10/19/23 revealed she required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and she was independent with eating. She lacked the ability to manage her own mediations/treatments and was usually continent. She had impaired memory

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recall and was able to make herself understood and she understood others. She was marked with falls and impaired hearing. She used a walker mobility device.

Review of R3's NSA dated 01/19/22 instructed facility staff to provide the following health services; management of her medications/treatments, bathing as needed, and one staff member to assist her to the bathroom as needed.

Review of R3's HSP under the section titled "Medications" was handwritten in the blank "See MAR".

Review of R3's MAR revealed the following: Bio freeze Gel 4% apply topically to affected area of left shoulder and neck as needed.

Interview on 04/30/24 at approximately 02:00PM with Operator A confirmed R1 and R3 keep the Bio freeze Gel in their rooms. She continued to state that R1 self-administers the treatment, and R3 keeps the topical in her room and R3 will "give it to the hospice nurse" when R3 receives her shower from the hospice nurse.

The operator failed to ensure the "Negotiated Service Agreements'" for R's 1 and 3 identified who was responsible for the management of selected "Over The Counter" (OTC) topical medications.