

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF OLATHE NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 791 N SOMERSET TERRACE OLATHE, KS 66062		
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S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure Survey with complaint investigations KS00176426, KS185916, KS00188342, KS188515, and KS00189151 conducted at the above named facility on August 19, 20,21 and 22, 2024.	S 000		
S 135 SS=D	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment. This STANDARD is not met as evidenced by: K.A.R. 26-39-103 (h)(1)(A)	S 135		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S 135	Continued From page 1 The facility reported a census of 32 residents. The sample included three residents and five closed record reviews. Based on record review and interview the executive director failed to ensure designated staff informed the resident's legal representative when the resident started having behaviors and new medication orders related to his behaviors for one (R6) of five closed records. Findings included: - An interview on 08/19/24 at 01:16 PM Administrative Nurse B reported for all residents, the "Functional Capacity Screen" (FCS) and the "Negotiated Service Agreement" (NSA) is one document and included some service plan direction. She reported there is an additional "Service Care Plan" that is more specific. - Review of R6's medical record revealed he moved into the facility on 02/23/20 with diagnoses of dementia and diabetes type II. R6's FCS/NSA dated 04/22/22 identified he needed physical assistance with bathing otherwise he was independent with activities of daily living. He was unable to manage his medications and had impaired cognition. R6's record included a medical provider's note dated 09/12/22 which stated: staff reported the resident had sexually inappropriate behaviors toward staff and other residents. New orders were written for Celexa (antidepressant) and Depakote (anticonvulsant) for sexual obsessions. R6's nursing progress notes dated 09/27/22 included documentation of the new orders but did not include that staff had notified R6's legal	S 135		

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S 135	Continued From page 2 representative. Review of R3's record lacked evidence the Licensed nurse notified R6's legal representative when he had a change in condition related to behaviors and the need for new medications related to his behaviors. Interview on 08/21/24 at 04:19 PM Administrative Nurse C acknowledged R6's record did not indicate his legal representative was notified of his behaviors or changes in medications. Administrative Nurse C reported when we get a new order we call or email the resident's legal representative and let them know of any changes. The executive director failed to ensure the licensed nurse notified R6's legal representative when he started to have sexually inappropriate behaviors and had new medications started related to his behaviors.	S 135		
S3101 SS=D	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: KAR 26-41-202 (h) The facility reported a census of 32 residents (R). The sample included three residents and five	S3101		

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S3101	Continued From page 3 closed record reviews. Based on interview and record review for one (R3) of three sampled residents, the executive director failed to ensure that everyone involved in the development of the Negotiated Service Agreement signed the agreement. Findings included: - An interview on 08/19/24 at 01:16 PM Administrative Nurse B reported for all residents, the "Functional Capacity Screen" (FCS) and the "Negotiated Service Agreement" (NSA) is one document and includes some service plan direction. She reported there is an additional "Service Care Plan" that is more specific. - Review of R3's "Electronic Medical Record" revealed he moved into the facility on 03/25/24 with diagnoses of Alzheimer's disease and asthma. R3's FCS/NSA dated 03/25/24 identified he needed supervision with bathing, dressing, toileting, and walking and required physical assistance with management of medications and medical treatments. He also had bladder incontinence, impaired cognition and had a risk or problem with falls. The FCS/NSA had not been signed by R3's legal representative. Review of R3's nursing progress notes included documentation on 04/30/24 that R3's FCS/NSA had been emailed to R3's legal representative for signatures. On 08/22/23 at 10:16 AM Administrative Nurse C reported the FCS/NSA is to be completed on the day of admission and should include signatures of the nurse and the resident's legal	S3101		

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S3101	Continued From page 4 representative. The executive director failed to ensure all who participated in the development of R3's FCS/NSA signed it.	S3101		
S3155 SS=E	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. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 32 residents (R). The sample included three residents and five closed record reviews. Based on observation, interview, and record review the executive director failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of two (R3 and R5) of three sampled residents who had an unplanned weight loss. Findings included: - An interview on 08/19/24 at 01:16 PM Administrative Nurse B reported for all residents,	S3155		

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S3155	Continued From page 5 the "Functional Capacity Screen" (FCS) and the "Negotiated Service Agreement" (NSA) is one document and includes some service plan direction. She reported there is an additional "Service Care Plan" that is more specific. - Review of R3's medical record revealed he moved into the facility on 03/25/24 with a diagnosis of Alzheimer's disease and type II diabetes. R3's "Functional Capacity Screen / Negotiated Service Agreement" (FCS/NSA) dated 03/25/24 revealed R3 needed supervision with eating, had impaired cognition and impaired decision-making ability. The FCS/NSA identified the resident had poor cognitive skills and nutritional needs "were met with staff assistance" and he needed reminders to go to meals in the dining room. It also directed staff to break tasks into smaller tasks and that he rarely made decisions. R3's Health Care Service Plan (HCSP) dated 03/25/24 included the same interventions as his FCS/NSA. R3's FCS/NSA and his HCSP lacked any direction for staff related to cueing and or helping R3 when he chooses to eat his meal in his room. R3's record included the following weights which indicated a weight loss of 10.2 pounds for a 5.4 % weight loss since admission to the facility. 04/05/2024 187.6 Lbs. 04/08/2024 187.0 Lbs. 05/16/2024 183.0 Lbs. 06/02/2024 181.0 Lbs. 07/01/2024 180.8 Lbs. 08/01/2024 177.4 Lbs.	S3155		

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S3155	Continued From page 6 Review of R3's nursing progress notes lacked any documentation related to the resident having weight loss or the resident refusing to come out to the dining room for evening meals. Observation of room trays gathered during the survey revealed multiple room trays (Styrofoam containers) , including trays from R3's room that had a large amount of food remaining in the Styrofoam tray. During a confidential interview, facility staff M reported R3 often does not come out for supper and staff do not go in and help him eat. Staff M reported a lot of room trays get thrown away that had not even been touched by the resident. Staff M reported R3 needed to come out and see others eating so he knows what to do with the food because if no one helps him in his room the container just sits because he doesn't know what to do with it. During a confidential interview facility staff N reported if a resident does not come out to eat the meal staff take the tray to the resident's room and set it on the table without helping the resident to eat and residents are losing weight because staff do not help them. During a confidential interview facility staff O reported the residents have dementia and some of them need help to eat their meals. When staff take a room tray back to R3 they just set it on the table, and no one goes in to help or cue him to eat his meal. An interview on 08/22/24 at 08:46 AM Executive Director acknowledged there were evening staff who were not doing their jobs, including not assisting residents with their meals and stated the	S3155		

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S3155	Continued From page 7 concerns brought to the surveyor's attention related to meals were probably true. An interview on 08/22/24 at 01:30 PM Administrative Nurse C reported if a resident received a room tray staff were supposed to take it to them and if they need assistance to eat the staff are supposed to help them eat. Administrative Nurse C reviewed R3's record and confirmed he had lost weigh and stated he eats a lot better when he eats out in the dining room and staff should be really trying to encourage him to come out for meals to eat. If he gets a room tray, she reported staff should at least make sure he starts to eat and help him if needed. The executive director failed to ensure a licensed nurse coordinated and implement health care services for R3 related to weight loss. - Review of R5's medical record revealed the resident moved into the facility on 08/01/22 with diagnosis of Dementia, major depressive disorder, and hypertension. R5's FCS/NSA dated 02/21/24 identified the resident needed physical assistance with eating, had impaired cognition and impaired communication. R5's FCS/NSA dated 06/24/24 included the same findings but also identified R5 had impaired vision. It identified staff provided physical assistance with eating and she received supplements. Staff were to check her weight monthly to make sure they met their goal, and her nutritional needs were met with staff assistance. Staff were to provide reminders to go to meals and required one staff member to feed her at all meals.	S3155		

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S3155	Continued From page 8 R5's "Health Care Service Plan" (HCSP) dated 06/24/24 included the same interventions as her FCS/NSA. Review of the resident's medical record included the following weights: 11/06/22 - 151.6 pounds (lbs.) 11/30/22 - 147.8 lbs. 12/01/22 - 147.8 lbs. 01/01/23 - 143.0 lbs. 02/22/23 - 139.2 lbs. 03/02/23 - 134.0 lbs. 04/02/23 - 131.6 lbs. - 20 pound loss in past five months equaling 13% weight loss. 05/03/23 - 128.8 lbs. The resident continued to have unplanned weight loss over the next six months. 11/24/23 - 107.8 lbs. for an additional 21 pounds equaling 16% weight loss. R5 continued to have additional unplanned weight loss over the next nine months with a current weight as of 08/01/24 of 91.6 lbs. totaling 31.4 pounds in the past year equaling 25% weight loss. Review of Nursing Notes from 11/19/22 lacked any documentation potential causes or additional interventions related to the resident's weight loss until 04/05/23 when the dietitian recommended house supplement four ounces twice a day due to weight loss. At this point the resident had already lost 20 pounds, 151.6 lbs. on 11/6/22 to 131.6 lbs. on 04/03/23 for a 13% weight loss with no additional interventions implemented to help support R5's nutritional status. The NN lacked documentation from the facility LN regarding weight loss or health care services	S3155			

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S3155	Continued From page 9 coordinated with nursing and dietary staff to promote weight gain and improved nutritional status. Review of the physician orders included the following: 04/05/23 - house supplement two time a day - give 4 ounces and record. 12/06/23 - hospice to eval and admit due to weight loss 12/08/23 - offer snacks three times a day for weight loss. 12/09/23 - offer resident carnation instant breakfast at morning meal. 12/11/23- weekly weights for weight loss. Observation on 08/19/24 at 12:21 PM R5 sat in high back wheelchair with crackers on the table and a glass of red liquid in front of her. There were n staff assisting her to eat her crackers or drink her fluids. Certified Medication Aide (CMA) P sat beside her and helped her eat her noon meal at 12:45 PM. Observation on 08/20/24 at 09:15 AM resident sat at the dining room table and did not have any staff sitting beside her o help her eat. The resident had a piece of toast and bacon on her plate. The resident felt around on the table and picked up her plate and tried to put it up to her mouth and the toast and bacon fell off her plate onto her lap. The resident kept rubbing the plate with her right hand feeling for food but there were no staff in the dining room to assist her. At 09:20 AM R5 took the straw out of her milk carton and lifted it to her mouth and drank directly out of the carton. Dietary staff Q removed R5's plate from the table and the resident did not eat any of her breakfast.	S3155		

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S3155	Continued From page 10 Observation on 08/20/24 at 09:31 AM Administrative Nurse B came into the dining room and asked staff to bring R5 a shake which Administrative Nurse B put into the resident's right hand. Executive director A then came into the dining room and helped R5 drink the shake and R5 drank 100%. Interview on 08/20/24 at 09:35 AM Dietary Staff R reported she gives R5 finger foods to eat when there is no staff to help her eat in the dining room. During a confidential interview facility staff M reported she had observed multiple times when staff were not around to help R5 eat her meal. Staff M stated R5 has very poor vision and staff would set her plate in front of her and expect her to feed herself. They would take her away from the table without helping her and she didn't eat any of her food. During a confidential interview facility staff N reported there used to be staff who worked evening who would take residents away from the table when they hadn't been served supper yet or when no one had helped them to eat their meal. Staff N reported R5 was one of the residents who would get taken away from the table frequently without staff helping her to eat her meal. An interview on 08/22/24 at 08:46 AM Executive Director acknowledged there were evening staff who were not doing their jobs, including not assisting residents with their meals and stated the interview and concerns brought to the surveyor's attention related to meals were probably true. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that meet the	S3155		

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S3155	Continued From page 11 needs for R5 regarding unplanned weight loss.	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. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(e) The facility reported a census of 32 residents. Based on interview and record review the administrator failed to ensure two of two newly hired Certified Medication Aides (CMA) were trained by a licensed nurse and delegated the nursing procedure for obtaining blood glucose checks according to the nurse practice act and amendments thereto. Findings included: - Interview on 08/19/24 at 11:28 AM Certified Medication Aide (CMA) E reported CMAs check residents' blood sugars. Review of the current personnel list included four Certified Medication Aides who were hired after Executive Director A was hired on 05/20/24 and included two other newly hired CMAs. On 08/20/24 at 11:23 PM Executive Director A	S3166		

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S3166	Continued From page 12 was unable to provide blood sugar delegation for CMA G who had checked R3's blood sugar multiple times in August 2024. Executive Director A reported she knew the facility was supposed to complete competencies but as far as she knew none had been completed since she had been employed on 05/20/24. Interview on 08/20/24 at 11:53 AM Administrative Nurse C reported she had not completed delegation/competency for blood sugar checks since she was hired on 07/22/24. The executive director failed to ensure a Licensed Nurse delegated the nursing procedure of checking a resident's blood sugar, for five newly hired CMAs.	S3166		
S3200 SS=E	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.	S3200		

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S3200	Continued From page 13 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 32 residents (R). The sample included three residents and five closed record reviews. Based on observation, interview, and record review the operator failed to ensure the administration of insulin was done by qualified staff in accordance with standards of practice for one (R3) of three sampled residents related to certified staff potentially piercing the resident's skin while holding an insulin pen up against the resident's skin for the resident to then push the plunger. Findings included: - An interview on 08/19/24 at 01:16 PM Administrative Nurse B reported for all residents, the "Functional Capacity Screen" (FCS) and the "Negotiated Service Agreement" (NSA) is one document and includes some service plan direction. She reported there is an additional "Service Care Plan" that is more specific. - Review of R3's medical record revealed he moved into the facility on 03/25/24 with diagnoses of Alzheimer's disease and type II diabetes. R3's FCS/NSA identified he needed physical assistance of staff to manage his medications and medical treatments. It identified he was able to self-administer his insulin after staff had prepared the insulin pen. Review of R3's self-medication assessment dated 08/21/24 identified "Resident is able to	S3200		

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NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF OLATHE NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 791 N SOMERSET TERRACE OLATHE, KS 66062		
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S3200	Continued From page 14 depress plunger on insulin pen with staff assistance to hold the insulin pen with the needle against the skin while providing verbal cues." Observation on 08/20/24 at 09:50 AM Certified Medication Aide (CMA) G went into room to give R3 his medications and insulin. R3 took his pills without any difficulty. CMA G had dialed R3's FIASP insulin to 2 units and explained to R3 he needed some insulin this morning. R3 pulled down the blanket and raised his shirt, CMA G wiped an area on R3's abdomen and went to hand R3 the insulin pen. R3 stated he wasn't going to do it and after a couple of attempts to get R3 to take the pen and self inject, CMA G stated he would have to tell the nurse and she will probably end up giving him his insulin as she usually does. Interview on 08/20/24 at 09:58 AM CMA E reported that when she is passing R3's medications she will usually go back and try again later if he will not do his insulin, especially if the nurse is not here. CMA E reported she normally takes the pen, places it against R3's skin and then he pushes down on the end of the pen (plunger). On 08/20/24 at 11:23 AM Executive Director A stated the facility did not have evidence of delegation/competency for newly hired employees requested and had not completed any delegation/competency since she was hired on 05/20/24. The executive director failed to ensure Certified Medication Aides only prepared the insulin pens for the resident to complete the injection process independently without staff holding the pens up against the resident's skin potentially piercing the	S3200			

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S3200	Continued From page 15 skin with the needle.	S3200		
S3202 SS=E	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(4) The facility reported a census of 32 residents. Based on interview and record review the administrator failed to ensure two of two newly hired Certified Medication Aides (CMA) and three additional newly hired CMAs were trained by a licensed nurse and delegated the nursing procedure of preparing and dialing an insulin pen to the ordered dosage for a resident to then self-inject according to the nurse practice act and amendments thereto. Findings included: - Review of the resident roster provided on 07/09/24 revealed two residents received insulin injections. Review of the current personnel list included four Certified Medication Aides who were hired after Executive Director A was hired and included two other newly hired CMAs who had been preparing insulin pens for residents since their hire date.	S3202		

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S3202	Continued From page 16 Review of R3's August 2024 medical record included initials from CMA G, CMA H, CMA I for preparation/administration of insulin without having had delegation completed by a licensed nurse. On 08/20/24 at 11:23 AM Executive Director A stated the facility did not have evidence of delegation/competency for newly hired employees requested and had not completed any delegation/competency since she was hired on 05/20/24. On 08/20/24 at 11:53 AM Administrative Nurse C reported she had not completed any delegation / competency for preparing insulin pens since she was hired on 07/22/24. The executive director failed to ensure the Licensed Nurse delegated the nursing procedure of preparing and dialing the dosage of an insulin pen, which is not included in the CMA curriculum, to three newly hired CMAs who had prepared insulin pens for each of the two residents to self-inject.	S3202		
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 17 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 32 residents(R). 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 for the licensed nurse or pharmacist to write the resident's full name on both the original manufacturer's medication package and the medication container/tube. Findings included: - On 08/19/24 at 11:28 AM "Certified Medication Aide" (CMA) E unlocked the medication cart for inspection. Observation of the 100/200 medication cart included two bottles of men's vitamins with a first name on the container and a box of refresh eye drops with a first name on the box and no name on the eye drop bottle. The medication cart also contained a box of Timolol Maleate eye solution and a box of Brimonidine Tartrate eye solution that had a first name on the box and no name on the eye drop bottle. On 08/19/24 at 11:37 AM CMA E unlocked the 400/300 medication cart which included a bottle of allergy tablets with a resident's first name on the box only. Interview on 08/19/24 at 11:35 AM CMA E	S3211		

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S3211	Continued From page 18 reported the CMA writes the residents' names on the medication bottles. Interview on 08/19/24 at 01:47 PM administrative Nurse B acknowledged all over-the-counter medications needed to have the resident's full name on the bottles and box and the nurse needed to be the one to put the name on the containers. The executive director failed to ensure a licensed nurse or pharmacist wrote the residents full name on all over-the-counter medications, including the medication package and container.	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	S3215		

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S3215	Continued From page 19 aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy 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: KAR 26-41-205(h)(1)(4) The facility reported a census of 32 residents. Based on observation and interview, the executive director failed to ensure staff stored medications according to manufacturer's recommendations related to the storage of insulin pens to ensure staff did not administer the medication beyond the manufacturer's recommended date of expiration. Findings included: - Observation on 08/19/24 at 11:28 AM Certified Medication Aide (CMA) E unlocked the medication cart for inspection Observation of the 100/200 medication cart included a FlexPen of Xultophy insulin with 150 units remaining and a FlexPen of Fiasp with approximately 80 units remaining with no date on either pen as to when staff-initiated use. On 08/19/24 at 11:40 AM CMA E confirmed the insulin pens did not have a date they were initiated into use.	S3215		

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S3215	Continued From page 20 Observation of the 300/400 hall medication cart included a Novolog FlexPen with 180 units remaining, a Glargine-Yfgn FlexPen with no date initiated on it with approximately 70 units remaining. It also included a Basaglar FlexPen with about 150 units remaining and a Novolog FlexPen with 50 units remaining and no date on either pen as to when it was initiated into use. On 08/19/24 at 01:27 PM Administrative Nurse B acknowledged insulin pens should have a date on them when put into use so that staff will know when they expire. Review of the Fiasp manufacture recommendations revealed to store at room temperature and discard after 28 days in use. Review of the Xultophy manufacturer recommendations revealed to store at room temperature and discard after 21 days in use. Review of the Glargine-Yfgn manufacturer recommendations revealed to store at room temperature and discard after 28 days in use. Review of the Basaglar manufacturer recommendations revealed to store at room temperature and discard after 28 days in use. Review of the Novolog manufacturer recommendations revealed to store at room temperature and discard after 28 days in use. The executive director failed to ensure designated staff wrote the date an insulin pen was first put in use and or date it expired to ensure it was not used past the manufacturers recommended date of expiration.	S3215		

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S3240	Continued From page 21	S3240		
S3240 SS=F	26-41-103 (c) Staff Development on Dementia (c) If the facility admits residents with dementia, the administrator or operator shall ensure the provision of staff orientation and in-service education on the treatment and appropriate response to persons who exhibit behaviors associated with dementia. This REQUIREMENT is not met as evidenced by: KAR 26-41-103 (c) The facility reported a census of 32 residents and identified all 32 residents had cognitive impairment. Based on interview and record review for five of five newly hired staff, the executive director failed to ensure the provision of staff orientation and in-service education on the treatment and appropriate responses to persons who may exhibit behaviors associated with dementia. Review of five newly hired staff records lacked evidence of orientation and in-service related to dementia. On 08/20/24 at 12:15 PM Executive Director A reported they facility did not have dementia training in their "new-hire orientation" and acknowledged they were supposed to. Executive Director A was unable to provide dementia training for newly hired staff. The executive director failed to ensure the provision of staff orientation and in-service education on the treatment and appropriate responses to residents regarding dementia	S3240		

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S3240	Continued From page 22 training.	S3240		
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: KAR 26-41-104(d)(3) The facility reported a census of 32 residents. Based on record review and interview for all employees and residents, the executive director failed to ensure disaster and emergency preparedness by failing to ensure performance of quarterly reviews of the facility's emergency management plan with all facility staff and residents. Findings included:	S3280		

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S3280	Continued From page 23 - Review of the information provided by Executive Director A on 08/19/24 revealed the following: Employees - 04/21/23 - reviewed with one staff: 05/23/23 - reviewed with 21 staff: and 01/25/24 reviewed with 10 staff. Residents - 04/21/23 - reviewed with 10 residents: 10/12/23 and 01/25/24 handouts to all residents. The information failed to included reviews for residents and employees in the first quarter of 2023, the third quarter of 2023 and the fourth quarter of 2023 for employees. It also failed to include reviews of the emergency management plan in the second quarter for 2024. On 08/19/24 at 02:24 PM Executive Director A reported the emergency management plan was supposed to be reviewed every quarter and with all residents and all employees. The executive director failed to ensure the facility's emergency plan was reviewed with all employees and 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	S3310		

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S3310	Continued From page 24 (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 32 residents (R). The sample included three residents, five closed record reviews, and five newly hired staff. Based on interview and record review for two (R3 and R4) of three sampled residents and two of five newly hired employee records the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This failure effected all residents who lived in the facility. Findings included: - Review of R3's record revealed he moved into the facility on 03/25/24. The resident's record included two TB skin tests but failed to include the date a licensed nurse read each result. Review of R4's record revealed he moved into the facility on 12/26/23. The resident's record included two TB skin tests but failed to include the date a licensed nurse read each result. Interview on 08/22/24 at 10:25 AM Administrative Nurse C reviewed R3 and R4's records and acknowledged the nurse failed to include the date that she read the TB skin test results.	S3310		

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S3310	Continued From page 25 The executive director failed to ensure resident records included all of the required information for accurately completing TB skin testing. - Review of 5 newly hired employees file revealed the following: Certified Medication Aide (CMA) J hired on 02/16/24 did not have a two-step TB skin test completed. Certified Nurse Aide K hired on 07/12/23 had a two-step TB skin test completed on 11/1/23 and 11/15/23, more than seen days after employment. Interview on 08/20/24 at 12:46 PM Executive Director A reported she was having trouble finding CMA J's two-step TB skin test and would continue looking. As of 08/22/24 at 09:00 AM Executive Director A had not provided TB skin testing for CMA J. Review of the "Tuberculosis (TB) Guidelines for Adult Care Homes" June 2013 h new resident and new employee shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within seven days of residency or employment. Each new resident and new employee shall receive a two-step TB skin test within seven days of residency or employment unless specific conditions are met. For two of three sampled residents and two of five new employee records, the administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		

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