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	N039004	A. BUILDING: _____ B. WING _____	10/31/2024

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COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 ccitations represent the findings of a Re-Licensure Survey for the above named Assisted Living Facility conducted on 10/29/24, 10/30/24, and 10/31/24.	S 000		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity 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; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201 (c)(1)(2) The facility reported a census of 15 residents (R). The sample included three residents. Based on interview, and record review the operator failed to ensure staff completed a "Functional Capacity Screen" for two (R4 and R5) of three sampled residents when they experienced a significant change in status and at least every 365 days. Findings included: - R4's medical record revealed she moved into the facility on 04/03/23 with diagnosis of dementia. R4's "Functional Capacity Screen" (FCS) dated	S3081		

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S3081	Continued From page 1 12/01/23 revealed she required physical assistance with bathing and dressing, was independent with toileting, transfers, and mobility. It also did not identify she was at risk for falls. R4's record included documentation she was admitted to a local hospice company on 09/11/24 upon return from the hospital status post fall with fractured left hip. Observation on 10/30/24 at 11:15 AM Certified Medication Aide (CMA) F walked with R4 to the dining room. R4 stated she couldn't walk very well because she had a bad leg. Interview on 10/30/24 at 01:40 PM CMA G reported staff had to help her with her showers once a week and Hospice does one per week as well. CMA G said staff helped R4 get dressed every morning, walked with her down to meals now, and made sure she used her walker. Interview on 10/31/24 at 10:25 AM CMA F reported staff had to remind R4 to use the restroom and make sure her brief is dry and help her with peri-care. Interview on 10/31/24 at 11:18 AM Operator A acknowledged R4 did not have a new FCS completed after she became a fall risk and returned from the hospital on Hospice services. Review of the "Admission and Discharge of a Tenant" policy dated 08/10/21 revealed staff shall conduct a FCS following a significant change in condition. The operator failed to ensure designated staff completed R4's FCS when she had a significant change in condition.	S3081		

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S3081	Continued From page 2 - R5 moved into the facility on 01/26/22 with diagnoses of hypothyroidism and low back pain. R5's current "Functional Capacity Screen" (FCS) dated 02/12/23 more than 200 days past due. Interview on 10/31/24 at 12:18 PM Operator A acknowledged R5's FCS had not been completed at least every 365 days. Review of the "Admission and Discharge of a Tenant" policy dated 08/10/21 revealed a FCS will be conducted at least every 365 days. The operator failed to ensure designated staff completed a FCS for R5 at least every 365 days.	S3081		
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.	S3085		

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S3085	Continued From page 3 This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a)(1)(2) The facility reported a census of 15 residents. The sample included three residents. Based on record review and interview the executive director failed to ensure designated staff completed two (R3 and R4) of three sampled resident's "Negotiated Service Agreement" based on the "Functional Capacity Screen" (FCS) and identified services to be provided based upon the FCS. Findings included: - R3 moved into the facility on 09/02/23 with a diagnosis of Parkinson's disease. R3's "Functional Capacity Screen" (FCS) dated 12/01/23 identified R3 was at risk for falls. R3s "Negotiated Service Agreement" (NSA) dated 12/01/23 does not identify the resident used a four wheeled walker for an assistive device for mobility. It identified R3 had a shuffled walk but failed to include services related to his fall risk as identified on the FCS. Interview on 10/31/24 at 12:45 PM Operator A reviewed R3's NSA and acknowledged it did not include that he used a four-wheeled walker for mobility or services related to his fall risk. The operator failed to ensure designated staff completed R4's NSA according to needs identified on his FCS. - R4's medical record revealed she moved into	S3085		

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S3085	Continued From page 4 the facility on 04/03/23 with diagnosis of dementia. R4's "Functional Capacity Screen" dated 12/01/23 revealed she was unable to manage her medical treatments and had impaired cognition. R4's "Negotiated Service Agreement" (NSA) dated 12/01/23 failed to identify services the facility would provide related to management of her medical treatments and impaired cognition. Interview on 10/31/24 at 11:15 AM Operator A acknowledged R4's NSA did not include services for medical treatments or for her impaired cognition. The operator failed to ensure designated staff identified services the facility provided for R4 on the NSA based on her identified FCS needs.	S3085		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement 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, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family.	S3092		

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S3092	Continued From page 5	S3092		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-202 (d)(1)(2)

The facility reported a census of 15 residents(R). The sample included three residents. Based on observation, interview, and record review the operator failed to ensure designated staff reviewed and revised the "Negotiated Service Agreement" for two (R4 and R5) of three sampled residents at least once every 365 days and when the resident had a significant change in status.

Findings included:

- R4's medical record revealed she moved into the facility on 04/03/23 with diagnosis of dementia.

R4's "Functional Capacity Screen" dated 12/01/23 revealed she required physical assistance with bathing and dressing, was independent with toileting, transfers, and mobility. It also did not identify she was at risk for falls.

R4's "Negotiated Service Agreement" (NSA) dated 12/01/23 failed to identify R4 had a significant change status post fall and admission to hospice services.

R4's record included documentation she was admitted to a local hospice company on 09/11/24 upon return from the hospital status post fall with fractured left hip.

Observation on 10/30/24 at 11:15 AM Certified Medication Aide (CMA) F walked with R4 to the dining room. R4 stated she couldn't walk very

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S3092	Continued From page 6	S3092		

well because she had a bad leg.

Interview on 10/30/24 at 01:40 PM CMA G reported staff had to help her with her showers once a week and Hospice does one per week as well. CMA G said staff helped R4 get dressed every morning, walked with her down to meals now, and made sure she used her walker.

Interview on 10/31/24 at 10:25 AM CMA F reported staff had to remind R4 to use the restroom and make sure her brief is dry and help with peri-care.

Interview on 10/31/24 at 11:18 AM Operator A acknowledged R4 did not have an amended NSA for when sh returned from the hospital and needed more assistance with cares and started Hospice services.

The operator failed to ensure designated staff reviewed/revised R4's NSA when she had a significant change in condition.

- R5 moved into the facility on 01/26/22 with diagnoses of hypothyroidism and low back pain.

R5's current "Functional Capacity Screen" dated 02/12/23 identified she was independent with all activities of daily living.

R5's current "Negotiated Service Agreement" (NSA) is dated 02/12/23, more than 200 days past due.

interview on 10/31/24 at 12:18 PM Operator A acknowledged R5's NSA had not been completed at least every 365 days.

Review of the "Admission and Discharge of a

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S3092	Continued From page 7 Tenant" policy dated 08/10/21 revealed an NSA will be completed every 365 days. The operator failed to ensure designated staff reviewed/revised R5's NSA at least every 365 days.	S3092		
S3171 SS=G	26-41-204 (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: KAR 26-41-204(i) The facility reported a census of 15 resident's (R). The sample included three residents. Based on observation, interview, and record review the operator allowed R4 to suffer severe pain for more that 24 hours by the failure to ensure a licensed nurse was notified the resident had a fall and complained of severe pain. R4 complained of severe pain for more than 24 hours without Licensed Nurse or Physician notification of the fall and severe pain which resulted in R4 being hospitalized for a fractured hip. Findings included: - Review of R4's record revealed she moved into the facility on 04/03/23 with diagnosis of dementia. R4's "Functional Capacity Screen" dated 12/01/23	S3171		

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S3171	Continued From page 8	S3171		

identified she needed physical assistance with bathing and dressing, had bladder incontinence, impaired cognition, and decision-making abilities. It did not identify she was at risk for falls.

R4's "Negotiated Service Agreement" dated 12/01/23 identified staff would assist with showers and dressing, she used a walker, but lacked any services related to fall risk.

Review of R4's medical record revealed the following facility staff documentation:
08/25/24 - first shift- Resident said she got up at 06:00 AM and fell into her front door. She has a carpet burn on her knee and skin tear on her arm. R4 complained of right hip pain when she took her 08:00 PM medications. R4 stated she had not fallen again since this morning. Certified Medication Aide H contacted R4's family and informed her she had fallen and had severe pain. R4's daughter said to give her Tylenol and she would check on R4 tomorrow.

08/26/24 - 2nd shift - around 10:20 PM daughter called the facility and stated she was taking R4 to the local hospital to get checked out since she was still complaining of pain. When staff went to dress R4, she continued to complain of severe pain in her right knee, would not sit up, and was just yelling. The Operator was called and helped transfer resident from her bed to the wheelchair. When R4's daughter came to take her to the hospital R4 refused to stand up to get into daughter's vehicle, so EMS was contacted.
08/26/24 - 3rd shift - 10:50 PM resident sat in wheelchair at front door with daughter waiting for EMS to take her to the hospital. R4 complained of severe right leg/hip/knee/and foot pain . Daughter returned later to get some of R4's belongings and stated she was going to a

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different hospital due to a fractured hip.

The record lacked evidence the staff on duty notified the Licensed Nurse (LN) or the medical provider when the resident initially fell on 08/25/24 and complained of severe pain additionally staff did not notify the nurse when the resident continued to complain of severe pain the next day on 08/26/24. The record also lacked evidence a Licensed Nurse assessed R4 for injuries post fall.

Surveyor requested investigations for the fall on 08/25/24 and previous falls on 09/17/23 and 05/23/24. Operator A provided one fall document titled "RN After Fall Assessment" dated 09/17/23that lacked a LN review for possible causal factors of the fall. Operator A was unable to provide investigations for the falls on 05/23/24 and 08/25/24 to ensure staff identified possible causal factors and interventions implemented to help decrease the risk of further falls.

An observation on 10/30/24 at 11:15 AM revealed Certified Medication Aide (CMA) F walked with R4 to the dining room. R4 stated she couldn't walk very well because she had a bad leg.

Interview on 10/30/24 at 01:00 PM with LN D reported the staff are supposed to call her when a resident falls. She reported she did not get a call about R4 falling and having severe pain on 08/25/24 or she would have come to the facility to assess her.

Interview on 10/31/24 at 08:13 AM LN C reported she shared on-call every other month with another nurse. LN C reported the staff call her when a resident falls and if they think the resident may have hit their head, they are to go to the emergency department. She reported she does

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S3171	Continued From page 10 not document anything in the record unless she comes to the facility to assess the resident. Interview on 10/31/24 Certified Medication Aide G reported the staff on duty will ask the resident if they are okay and check for any skin tears. We get their vitals and then get ahold of the nurse and the operators. If the nurse doesn't answer she ends up calling us back and we tell them what happened and if there were any injuries. Interview on 10/31/24 at 11:15 AM Operator A reported when a resident falls the staff are supposed to call the nurse and then the nurse is to assess the resident for any injuries after the fall. The surveyor requested policy for falls on 10/31/24 and Operator reported they did not have a policy for falls. The operator allowed harm when R4 suffered severe pain for more that 24 hours by the failure to ensure a licensed nurse was notified the resident had a fall and complained of severe pain. R4 complained of severe pain for more than 24 hours without Licensed Nurse or Physician notification of the fall and severe pain which resulted in R4 being hospitalized for a fractured hip.	S3171		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (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	S3175		

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S3175	Continued From page 11 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: KAR 26-41-205(a)(1) The facility reported a census of 15 residents (R). The sample included three residents. Based on observation, interview, and record review the administrator failed to ensure a licensed nurse completed an assessment for self-administration of medications for one (R5) of three sampled residents at least annually. Findings included: - R5's medical record revealed she moved into the facility on 01/26/22 with diagnosis of hypothyroidism and low back pain. R5's "Functional Capacity Screen dated 02/12/23 identified R5 was independent with management of medications. R5's 'Negotiated Service Agreement" dated 02/12/23 identified the resident self-administered her medications.	S3175		

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S3175	Continued From page 12 R5's medical record included an "Assessment for Self-Administration of Medications' dated 02/12/22. The record lacked evidence of annual assessments to ensure R5 could self administer her medications. Observation on 10/30/24 at 12:30 PM R5 kept her medication bottles in her kitchen cabinet and also had a medication planner on the counter with a list of medication under it. R5 reported her daughter helps her set up her medications if she needs any help. Interview on 10/31/24 at 12:18 M Operator A reported the nurses were supposed to be doing the self-administration assessments annually. The operator failed to ensure a Licensed Nurse completed a self-medication assessment for R5 at least annually.	S3175		
S3200 SS=F	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	S3200		

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S3200	Continued From page 13 medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) The facility reported a census of 15 residents (R). The sample included three residents. Based on interview and record review the operator failed to ensure facility staff administered one (R4) of three sampled resident's medications in accordance with a medical care providers written order and standards of practice. The operator also failed to ensure facility staff followed standards of practice related notify a Licensed Nurse when new physicians orders are received to ensure medications are administered according to the physician's orders. Findings included: - R4's medical record revealed she moved into the facility on 04/03/23 with diagnoses of dementia and anxiety. R4's "Functional Capacity Screen" dated 12/1/23 revealed she was unable to participate in management of medications and medical treatments. R4's "Negotiated Service Agreement" revealed Certified staff would administer medications as ordered. Review of R4's September 2024 "Medication Administration Record" (MAR) included an order	S3200		

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S3200	Continued From page 14 for Norco (narcotic pain medication) 5/325 milligrams (mg) one tablet every six hours for pain. Facility staff failed to document nine out of 20 times for the 01:00 AM dose. Review of R4's October 2024 MAR included the same Norco order and staff failed to document administration 11 out of 29 times. Interview on 10/31/24 at 11:15 AM Operator A reported the times at 01:00 AM that medications were not initialed were when the staff on duty were not qualified to administer medications and someone did not come in and administer them. The operator failed to ensure qualified staff administered R4's pain medication as ordered by the medical provider. - During the survey process on 10/29/24, 10/30/24,10/31/24 surveyor identified a Licensed Nurse (LN) was not routinely in the facility to review physician's orders and facility staff did not call a LN to let her know when a new medication was ordered. The "orders" were written on the "Medication Administration Record" (MAR) by the CMA and not always reviewed by a LN for days later. 1. R3's medical record revealed he moved into the facility on 09/02/23, could not manage his medications, and certified staff would administer his medications as ordered. R3's medical record included a medical providers order dated 07/18/24 to discontinue his timolol, start Cosopt twice a day both eyes and continue Latanoprost both eyes at bedtime that was not reviewed/noted by a LN until 07/28/24.	S3200		

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S3200	Continued From page 15 2. R4's medical record revealed she moved into the facility on 04/03/23, could not manage her medications, and certified staff would administer her medications as ordered. R4's medical record included a physician's order dated 07/23/24 to increase R4's Paroxetine to 20 milligrams daily in the evening that was not reviewed/noted by a LN until 07/28/24. Interview on 10/30/24 at 01:00 PM LN D reported there is a notebook in the medication room that she checks to see if there are any new orders to review. She stated she was not sure how they were added to the MAR because she does not put the orders on the MAR and does not check it. She stated sometimes they will call me when there is a new order and sometimes, they don't. Interview on 10/31/24 at 07:35 AM LN C reported she goes to the facility on Fridays and reviews orders and the MAR at that time. She acknowledged it may be a week before she reviews new orders and the MAR. Interview on 10/31/24 at 08:14 AM Certified Medication Aide (CMA) F reported medical providers, or the pharmacy will send new orders either via fax or after an office visit. CMA F stated the new orders are put in the new order notebook so the nurse will know we got a new order, and the CMA will write the order on the MAR. CMA F acknowledged they are supposed to call the nurse to let her know there are new orders but that does not always happen. According to the "Kansas Certified Medication Aide Curriculum" dated 05/10/2013 revealed The Licensed Nurse will give the medication aide verbal or written instructions for administration of	S3200		

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S3200	Continued From page 16 the medication. The medication aide must record the phone call to the nurse and the directions provided by the nurse in the resident's clinical record. The nurse must also record the directions given to the medication aide in the resident's clinical record on the next visit to the facility. The operator failed to ensure a the CMA contacted the LN to review and provide instructions for administering new medications to ensure medications were administered according to the medical providers orders.	S3200		
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 15 residents(R). Based on observation and interview, the executive director/licensed nurse failed to ensure	S3211		

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S3211	Continued From page 17 a licensed nurse or pharmacist included the residents full name on all over-the-counter medications, including the original manufacturer's medication package and the medication container/tube. Findings included: - During initial tour on 10/29/24 at 12:29 PM Certified Medication Aide (CMA) F unlocked the medication cart for inspection. The top drawer contained a bottle of acetaminophen labeled "stock" and CMA F reported it was for any resident who did not have their own bottle to use. In another drawer was a basket with a residents last name that included a bottle of vitamin D3, bottle of refresh eye drops, and three individual doses of Restasis eye drops, all without a resident's full name on the medication container. 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		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by	S3248		

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S3248	Continued From page 18 a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(1)(2) The facility reported a census of 15 residents. Based on record review of two newly hired employees, the operator failed to have evidence of registry/Licensure verification and criminal background check completed for two of two newly hired staff who required specialized education and training verified upon hire. The findings included: - Review of two of two newly hired staff files revealed the following: 1. Licensed Nurse (LN) C hired on 11/02/23 had her licensure checked on 04/10/24, nearly five months after her hire date. 2. Certified Nurse Aide (CNA) E hired on 08/20/24 had her registry check and criminal background check completed on 10/29/24, nearly two months	S3248		

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S3248	Continued From page 19 after her hire date. On 10/29/24 at 02:02 PM Administrative staff B acknowledged she had not completed the registry and criminal checks upon hire for LN C and CNA E. The operator failed to ensure designated staff conducted registry /licensure checks and criminal background checks for verification of of certification/licensure prior to working at the facility.	S3248		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 15 residents(R). The sample included three residents. Based on interview and record review the operator failed to ensure two (R3 and R4) of three sampled residents records contained documentation of all incidents, symptoms, and other indications of illness or injury, what staff did, and the results of action taken. Findings included:	S3261		

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S3261	Continued From page 20 - R3 moved into the facility on 09/02/23 with a diagnosis of Parkinson's disease. R3's "Functional Capacity Screen" (FCS) dated 12/01/23 identified R3 was unable to participate in bathing and medication management and was at risk for falls. R3s "Negotiated Service Agreement" (NSA) dated 12/01/23 identified the resident had a shuffled gait and certified staff administered medications. Review of R3's facility staff notes revealed the following: 10/30/23 - resident lethargic and confused and taken to local hospital for evaluation. 10/20/23 - returned from the emergency room. The record lacked nursing assessment status post emergency department return. 11/06/23 - resident tested positive for COVID, denies symptoms and felt OK. The record lacked any further nurse assessment of follow up after testing positive for COVID. 07/31/24 - staff observed resident on his living room floor and unable to recall how he fell. The record lacked nurse assessment and follow up post fall. 08/25/24 - Staff found resident on his living room floor, got him up and into his recliner. The record lacked nurse assessment and follow up post fall. 10/04/24 - resident found on floor by staff at 08:27 AM and again at 10:15 AM. The record lacked nurse follow up post fall. Interview on 10/30/24 at 01:00 PM Licensed Nurse (LN) D reported there is a place to document in the resident's chart and they also have a computer the facility started using for	S3261		

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documentation of resident's status. She reported documentation should include anything out of the ordinary.

Interview on 10/31/24 at 07:35 AM LN C reported she would expect nursing documentation to include any time the nurse communicates with the physician, if a resident falls or something happens. LN C acknowledged she had not been documenting in the chart as often as she probably should be.

The operator failed to ensure R3's record included documentation of all symptoms, incidents, illness, the action taken, and results of action related to falls, COVID, and hospital return status post lethargy.

- R4's medical record revealed she moved into the facility on 04/03/23 with diagnosis of dementia.

R4's "Functional Capacity Screen" dated 12/01/23 revealed she needed physical assistance with dressing and bathing and was unable to manage her medications and medical treatments. She also had bladder incontinence and impaired cognition.

R4's "Negotiated Service Agreement" (NSA) dated 12/01/23 revealed staff assisted R4 with dressing and showers and administered her medications as ordered.

Review of R4's medical record included the following staff documentation:
09/17/23 - fell in living room today with a small bump on the back of her head and sore left elbow.
The record lacked nurse assessment for injuries

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or follow up post fall.
11/06/23 - received new orders to discontinue Gemtesa (treat overactive bladder).
The record lacked follow up related to changes in medications.
05/25/24 - noticed some bruising under her eyes today possible from the fall a couple of days ago.
The record lacked documentation of R4 having a fall, nurse assessment or follow up post fall.
07/03/24 - received order to restart her antibiotic.
The record lacked documentation of the resident being on an antibiotic previously and any symptoms related to the need for antibiotics.
08/25/24 - resident said she got up at 06:00 AM and fell into her door. The record lacked notification of Licensed Nurse (LN), LN assessment or follow post fall.
09/10/24 - returned to facility will need a lot of assistance with everything.
The record lacked a LN assessment status hospital return from a fall with fractured hip.

Interview on 10/30/24 at 01:00 PM Licensed Nurse (LN) D reported there is a place to document in the resident's chart and they also have a computer the facility started using for documentation of resident's status. She reported documentation should include anything out of the ordinary.

Interview on 10/31/24 at 07:35 AM LN C reported she would expect nursing documentation to include any time the nurse communicates with the physician, if a resident falls or something happens. LN C acknowledged she had not been documenting in the chart as often as she probably should be.

The operator failed to ensure R4's record included documentation of all symptoms,

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S3261	Continued From page 23 incidents, illness, the action taken, and results of action related to falls, medication changes and post hospital return.	S3261		
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 15 residents. Based on record review and interview for all employees and residents, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly reviews of the facility's emergency management plan with all residents and facility staff.	S3280		

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S3280	Continued From page 24 Findings included: - On 10/29/24 at 01:36 PM Operator A provided a notebook that was where designated staff were t document reviews of the emergency management plan and she reported "the reviews have not been done." The operator failed to ensure disaster preparedness by the failure to ensure designated staff completed quarterly reviews of the emergency management plan with all residents and facility employees.	S3280		
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 reported a census of 15 residents. Based on observation and interview the operator failed to ensure designated staff stored all food under safe and sanitary conditions. Findings included: - Observations during the kitchen tour on 10/29/24 at 11:52 AM revealed the following: Plastic container in the double refrigerator labeled	S3299		

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S3299	Continued From page 25 chicken salad and dated 9/22-9/26. Plastic container in the double refrigerator dated 09/27 with yellow food item that had mold in it. Grocery sack with small baggies with food item in it not dated or labeled. Package of potato patties open and not sealed. Package of frozen waffles open and not sealed. Package of long sausage wrapped in cellophane and not labeled or dated. Baggie with 1/2 chub of hamburger not dated or labeled. Fish Filet in a baggie not dated or labeled. Bag with White food item not dated or labeled. On 10/29/24 at 12:12 PM Administrative staff B reported the food items in refrigerator should have cleaned out and the undated baggies and other items in the freezer needed to be dated, labeled and sealed. The operator failed to ensure designated staff stored foods in manner to ensure they were sealed, dated, and labeled when stored in the freezer.	S3299		
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 the facility ' s compliance with the department ' s	S3310		

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S3310	Continued From page 26 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 15 residents (R). The sample included three residents and two newly hired staff. Based on interview and record review for three (R3, R4, R5) of three sampled residents and two of tow newly hired staff the operator failed to ensure the facility remained in compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Review of two newly hired employees revealed the facility hired Licensed Nurse C on 11/29/23 and Certified Nurse Aide E on 08/20/24 and neither had a TB symptom screen completed or a two-step TB skin test completed. On 10/29/24 at 01:58 PM Operator A looked through employee files and confirmed neither employee had a TB symptom screen and a TB skin test completed. The Operator failed to ensure the facility remained in compliance with TB guidelines for two newly hired employees. - Review of three of three resident records revealed the following: 1. Review of R3's record revealed he moved into	S3310		

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the facility on 09/02/23. The resident's record failed to include a second TB skin test completed upon moving into the facility and failed to include an annual TB skin test.

2. Review of R4's medical record revealed she moved into the facility on 04/03/23. The resident's record failed to include an annual TB symptom screen.

3. Review of R5's medical record revealed she moved into the facility on 01/26/22. The resident's record failed to include an annual TB symptom screen.

Interview on 10/30/24 at 12:51 PM Licensed Nurse D reported she did not do any TB skin testing at the facility and thought they could be done at the health department or the medical providers office.

Review of the facilities policy for admission dated 08/10/21 included residents will have a TB skin test done within seven days of admission and then have a yearly TB test or screening.

The operator 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 by failing complete TB symptom screening annually and completing a second TB skin test for three of three sampled residents.