STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021006	A. BUILDING: _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARTEN COUNTRYSIDE HOME INC	2454 HWY 15 NORTH ABILENE, KS 67410

(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 are the result of a Licensure Resurvey at the above named Residential Health Care Facility in Abilene, Kansas on 02/28/17, 3/01/17, 3/02/17, 3/06/17, 3/07/17, and 3/08/17. Complaints #112157, #110012, and #109883 also investigated.	S 000		
S 140 SS=D	26-39-103 (i) Resident Right Privacy and Confidentiality (i) Privacy and confidentiality. The administrator or operator shall ensure that each resident is afforded the right to personal privacy and confidentiality of personal and clinical records. (1) The administrator or operator shall ensure that each resident is provided privacy during medical and nursing treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. (2) The administrator or operator shall ensure that the personal and clinical records of the resident are maintained in a confidential manner. (3) The administrator or operator shall ensure that a release signed by the resident or the resident's legal representative is obtained before records are released to anyone outside the adult care home, except in the case of transfer to another health care institution or as required by law. This STANDARD is not met as evidenced by: KAR 26-39-103(i) The census equalled 10 the sample included three Residents, and two focused reviews completed. Based on observation, interviews, and reviews of record, for one of three sampled	S 140		

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

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S 140	Continued From page 1 (#189), the Operator failed to develop and implement policy and procedure to ensure Residents afforded the right to privacy and confidentiality during medical and nursing treatment, personal care, visits, and meetings of family, related to the use of a video monitor in Resident's room that provided visual transmission of all room activity to the open nurse desk and south dining and hallway area of facility. Findings included: - By interview on 02/28/17 at 10:45am, during the entrance conference, Owner/Operator/RN (registered nurse) stated we have a video monitor (baby monitor) in one room... #189... camera is at the nurse's station... audio is turned off, you can turn up volume... so forgetful in calling us for assistance... family brought it, they are aware... do not know if it is on NSA (negotiated service agreement) or HSP (health service plan). - By observation on 02/28/17 at 2:30pm, in the open nurse desk area attached to the south dining room and hallway of facility, a video screen approximately five inches by eight inches sat on a horizontal shelf above the nurses' desk. On display, a Resident sitting in a recliner watching TV in his/her room. No staff at desk at time of this observation. By interview on 02/28/17 at 2:30pm, Owner/Operator/RN confirmed monitor view visible to anyone in hallway or south dining area of facility... confirmed unless someone sitting at desk watching screen, would not see #189 attempt mobility without assistance... not an effective means of preventing falls for #189. The current functional capacity screen (FCS) of	S 140		

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S 140	Continued From page 2 11/07/16 assessed #189 in need of physical assistance with bathing, dressing, toileting, transfers, mobility, medication and treatment management; with short and long term memory impairment, memory recall and decision making impairment; with bladder incontinence, falls and unsteadiness. By review, the current NSA/HSP for #189 dated 11/07/16 lacked a fall prevention plan, and lacked mention of a video monitoring device used to prevent falls. The Operator failed to develop and implement policy and procedure to ensure #189 afforded the right to privacy and confidentiality during medical and nursing treatment, personal care, visits, and meetings of family, related to the use of a video monitor in a Resident's room that provided visual transmission of all room activity to the open nurse's desk, hall, and south dining area of facility.	S 140		
S 200 SS=D	26-39-102 (g) Written Discharge Notice Requirements (g) Each written transfer or discharge notice shall include the following: (1) The reason for the transfer or discharge; (2) the effective date of the transfer or discharge; (3) the address and telephone number of the complaint program of the Kansas department on aging where a complaint related to involuntary transfer or discharge can be registered; (4) the address and telephone number of the state long-term care ombudsman; and (5) for residents who have developmental disabilities or who are mentally ill, the address and telephone number of the Kansas advocacy	S 200		

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S 200	Continued From page 3 and protection organization. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(g) The census equalled 10 the sample included three Residents, with two focused reviews completed. Based on interview and review of record, for one of two focused reviews who received a written discharge notice (#184), the Operator failed to ensure the written discharge notice included all required information. Findings included: - Review of record revealed #184 admitted to facility 3/28/16 with diagnoses of Hypertension, Diabetes, Left leg wound, Cellulitis, Congestive heart failure, Anemia, and Left knee replacement. The medical record contained an 11/10/16 letter to the family of #184: "This is a notice for a involuntary discharge due to Resident is unable to participate in the personal daily cares. Resident is a danger to self as he/she does not use call light to have staff come to assist with getting up and activities of daily living, resulting in multiple falls. The Resident has failed after reasonable and appropriate notice, to try to change. Residents' needs are not able to be met at this time. Operator notifies family. Operator notifies physician." The notice failed to include the effective date of the discharge. The notice failed to include the address and	S 200		

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S 200	Continued From page 4	S 200		

telephone number of the complaint program of the Department on aging where a complaint related to involuntary transfer or discharge could be registered, and
The notice failed to include the address and telephone number of the state long-term care ombudsman.

By review of the facility policy and procedure for involuntary discharge, the following noted:

"All transfers shall include: the reason for the transfer, the effective date of transfer the address and telephone of the complaint department of the Kansas Department on Aging where a complaint related to involuntary transfer can be discharged,the address and telephone of the state long term care ombudsman..."

The medical record contained the following Nurse's Notes:
11/16/16 - 10:00am - Resident has been admitted to the hospital (fell in bathroom at 7:30am while being assisted with morning care)

11/16/16 - 4:00pm - Resident needs can no longer be met at Facility. Family will seek placement elsewhere. resident discharged as of today.

By interview on 3/01/17 at 3:10pm, Owner/Operator/RN (registered nurse) confirmed this the only discharge notice presented to family/Resident... confirmed this notice did meet Department requirements for discharge and did not meet facility policy and procedure for involuntary discharge.

The Operator failed to ensure the written discharge notice for #184 included all required

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S 200	Continued From page 5 information.	S 200		
S 225 SS=E	26-39-102 (a) Admission Policy (a) Each licensee, administrator, or operator shall develop written admission policies regarding the admission of residents. The admission policy shall meet the following requirements: (1) The administrator or operator shall ensure the admission of only those individuals whose physical, mental, and psychosocial needs can be met within the accommodations and services available in the adult care home. (A) Each resident in a nursing facility or nursing facility for mental health shall be admitted under the care of a physician licensed to practice in Kansas. (B) The administrator or operator shall ensure that no children under the age of 16 are admitted to the adult care home. (C) The administrator or operator shall allow the admission of an individual in need of specialized services for mental illness to the adult care home only if accommodations and treatment that will assist that individual to achieve and maintain the highest practicable level of physical, mental, and psychosocial functioning are available. (2) Before admission, the administrator or operator, or the designee, shall inform the prospective resident or the resident ' s legal representative in writing of the rates and charges for the adult care home's services and of the resident's obligations regarding payment. This information shall include the refund policy of the adult care home.(3) At the time of admission, the administrator or operator, or the designee, shall execute with the resident or the resident ' s legal representative a written agreement that describes in detail the services and goods the resident will	S 225		

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S 225	Continued From page 6 receive and specifies the obligations that the resident has toward the adult care home. (4) An admission agreement shall not include a general waiver of liability for the health and safety of residents. (5) Each admission agreement shall be written in clear and unambiguous language and printed clearly in black type that is 12-point type or larger. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(a)(1)(C)(2)(3) The census equalled 10 the sample included three Residents, with two focused reviews completed. Based on interview and record review, for two of three sampled, (#189 and #187) and for one of two focused reviews (#186), the Operator failed to execute a written agreement at the time of admission that described in detail the services and goods the Resident to receive and specified obligations of the Resident to the facility. Findings included: - Review of record revealed #189 admitted to facility 11/07/16 with diagnoses of Cerebrovascular accident, Breast cancer, Depression, Diabetes, Atrial fibrillation, Osteoporosis, Dementia, Microvascular disease, Hypertension, and Recent fracture of right humerus. The current 11/07/16 functional capacity screen (FCS) assessed #189 in need of physical assistance with Bathing, Dressing, Toileting, Transfers, Mobility, Medication and treatment	S 225		

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S 225	Continued From page 7	S 225		

management; with bladder incontinence, short term and long term memory impairment, decision making and memory recall impairment, with falls/unsteadiness, vision and hearing impairments; used a walker and wheelchair.

The negotiated service agreement (NSA) initiated 11/07/16, signed 11/16/16, documented facility staff to provide assistance with these identified needs.

The NSA and the Admission agreement each completed 11/16/16, nine days after #189 admitted to facility.

- Review of record revealed #187 admitted to facility 01/19/16 with diagnoses of Renal failure, Gastroesophageal reflux disease, Hypertension, Bout, Depression, Anxiety, Frequent stasis ulcers, Esophageal stricture, Forgetfulness, and Anemia.

The current FCS of 01/19/17 assessed #187 in need of physical assistance with bathing, medication and treatment management, bladder incontinence, short term memory impairment, memory recall impairment, and decision making impairment; used a walker and a lift chair. The previous FCS of 6/30/16 coded the same, with the addition of supervision for mobility.

The Admission agreement completed 01/20/16, one day after #187 admitted to facility.

- Review of record revealed #186 admitted to facility 11/10/16 with diagnoses of Fracture of right hip with pneumonia, Atrial fibrillation, Diabetes, Hypertension, Congestive heart failure,

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S 225	Continued From page 8 Renal failure, Breast cancer, Macular degeneration, and Anemia. The current 11/10/16 FCS assessed #186 in need of physical assistance with Bathing, Dressing, Toileting, Transfers, Mobility, Medication and treatment management; with bladder incontinence; with impaired short term and long term memory, impaired memory recall and decision making; with falls and unsteadiness. The NSA initiated 11/10/16, signed 11/15/16, documented facility staff to provide assistance with these identified needs. The NSA and the Admission agreement each completed 11/15/16, five days after #186 admitted to facility. The medical records lacked evidence any written information given to Resident prior to admission or at time of admission, to inform of rates, charges, services offered, and Resident payment obligations. On 3/02/17 at 11:02am and at 11:12am, Owner/Operator/RN (registered nurse) confirmed the admission agreements for #189 and #186 not completed on or before Resident admission to facility... stated we usually go over everything on day of admission... then we re-type the NSA and have them sign it when they come in next... The Operator failed to notify in writing or obtain a written agreement with Resident or Resident representative detailing rates and charges and payment obligations of #189, #187, and #186, on or before their admission to the facility.	S 225		

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S3028	Continued From page 9	S3028		
S3028 SS=F	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(B)(C)(D)(E)(F) The census equalled 10 the sample included three Residents with two focused reviews completed. Based on interview and review of	S3028		

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S3028	Continued From page 10	S3028		

record, for one of three sampled (#189) and for two of two focused reviews (#186 and #184), with allegations of potential abuse or neglect, the Operator failed to:
Report potential abuse or neglect to the department within 24 hours,
Thoroughly investigate allegations of potential neglect or abuse within five working days, and,
Maintain a written record of each investigation.

Findings included:

- Review of record revealed #189 admitted to facility 11/07/16 with diagnoses of Cerebrovascular accident, Breast cancer, Depression, Diabetes, Atrial fibrillation, Osteoporosis, Dementia, Microvascular disease, Hypertension, and Recent fracture of right humerus.

The current 11/07/16 functional capacity screen (FCS) assessed #189 in need of physical assistance with Bathing, Dressing, Toileting, Transfers, Mobility, Medication and treatment management; supervision with eating; with bladder incontinence, short term and long term memory impairment, decision making and memory recall impairment; with falls/unsteadiness, vision and hearing impairments; used a walker and wheelchair.

The 1/07/16 negotiated service agreement (NSA) documented physical assistance with dressing, toileting, incontinent care, ambulation, and transfers, facility to administer medications and encourage activities.

The 11/07/16 Resident Care Plan documented staff assist with dressing, undressing, toileting, changing briefs, assist with all transfers and

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S3028	Continued From page 11	S3028		

ambulation; staff to walk with using gait belt and walker; make sure has call light at all times and remind to call for assistance; check on frequently day and night.

Nurse ' s Notes of medical record documented: 11/30/16 - 935 - Resident fell in room... did not use call light... decided to go to bathroom and must of turned wrong and fell to floor... has rug burn on right elbow... denies pain... instructed to use call light

The medical record lacked an investigation to rule out potential neglect when a cognitively impaired Resident attempted to independently complete services that required physical assistance by staff. #189 experienced an unwitnessed fall, and sustained a minor injury. The medical record lacked evidence of a report to the Department.

02/05/17 - 5:00am - Resident checked at 5am... sitting at side of bed and states fell out of bed... #189's right hand is purple and swollen, sent to ER (emergency room).

02/05/17 - 8:45am - returned from ER with splint on fingers... too swollen to put cast on... also has urinary tract infection... will start Cipro...

The medical record lacked an investigation to rule out potential abuse or neglect when a cognitively impaired Resident experienced an unwitnessed fall, and sustained an injury. The medical record lacked evidence of a report to the Department.

By interview on 3/02/17 at 12:10pm, Owner/Operator/RN (registered nurse) confirmed the two falls above not reported to Department... completed an incident report for the 02/05/17 event, but did not complete a thorough

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S3028	Continued From page 12 investigation to rule out abuse or neglect. The Owner/Operator/RN provided the facility policy and procedure for Abuse, Neglect, Exploitation (ANE) By review the facility policy and procedure for ANE specified: No Resident shall be subjected to ANE Each allegation of ANE shall be reported to the Operator as soon as staff aware and to the Department within 24 hours Investigation shall be started when Operator receives allegation Immediate measures shall be taken to prevent further ANE Each alleged violation shall be thoroughly investigated within five working days... The Department report shall be submitted within five working days A written record is to be maintained The Operator failed to report potential neglect or abuse of #189 to the department within 24 hours, failed to thoroughly investigate allegations of potential abuse or neglect, and failed to maintain a written record of investigations. - Review of record revealed #186 admitted to facility 11/10/16 with diagnoses of Fracture of right hip with pneumonia, Atrial fibrillation, Diabetes, Hypertension, Congestive heart failure, Renal failure, Breast cancer, Macular degeneration, and Anemia. The current 11/10/16 FCS assessed #186 in need of physical assistance with Bathing, Dressing, Toileting, Transfers, Mobility, Medication and treatment management; supervision with eating; with bladder incontinence; with impaired short	S3028		

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S3028	Continued From page 13	S3028		

term and long term memory, impaired memory recall and decision making; usually understandable and sometimes understands for communication; with falls and unsteadiness, vision impairment; used a walker.

The 11/10/16 negotiated service agreement (NSA) documented physical assistance with dressing, toileting, incontinent care, ambulation, and transfers, facility to administer medications and encourage activities.

The 11/10/16 Resident Care Plan documented staff assist with ambulation and transfers, with bathing after done with home health, with dressing/undressing, keep call light within reach at all times; keep pressure off heels; follow all hip precautions...

Nurse's Notes of medical record documented:
12/31/16 - 7:00pm - staff called over RN (registered nurse) to see Resident... is screaming/agitated, states is dying... Durable Power of Attorney (DPOA) and spouse took Resident to ER (emergency room) to be evaluated... is dehydrated... coming back to facility... DPOA to spend night with Resident...

01/01/17 - 3:00pm - found pantless... mumbled when asked what happened... assisted to dress... in recliner...

01/01/17 - 3:10pm - notified physician of fever, hallucinations, talking to unseen people... yelling and screaming he/she is dying... orange cloudy urine... called ambulance to pick up Resident... admitted

01/02/17 - DPOA called to state Resident would not be coming back to facility

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(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
S3028	Continued From page 14 Medical Record contained an 01/01/17 Hospital History and physical: Confusion that has increased and gotten worse... urinary tract infection... hallucinating and running a fever today... "there has also been some concern in speaking with DPOA if someone is mistreating #189 at the facility... more issues with anxiety... DPOA was told by staff of mistreatment by another aide... patient made statements that there is a lady where he/she lives that is mean... tells him/her to behave and firmly tells to sit down... I am not a bad person... don't know why she says that... why would Owner/Operator/RN have her work there... The medical record lacked an investigation to rule out potential abuse when a cognitively impaired Resident shared potential allegations of abuse occurring by staff on duty in the facility. By interview on 3/02/17 at 11:10pm, Owner/Operator/RN (registered nurse) confirmed the allegations of abuse noted above not reported to Department... attempted to call Complaint Hotline, never got an answer... did not complete a thorough investigation to rule out abuse... did have a staff meeting and cautioned staff about talking to family members about other staff members... #186 did not return to facility after 01/01/17 hospital transfer. The Operator failed to report potential abuse of #186 to the department within 24 hours, failed to thoroughly investigate allegations of potential abuse, and failed to maintain a written record of investigations. - Review of record revealed #184 admitted to	S3028		

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S3028	Continued From page 15 facility 3/28/16 with diagnoses of Hypertension, Diabetes, Left leg wound, Cellulitis, Congestive heart failure, Anemia, Hyponatremia, and Left knee replacement. The 6/01/16 functional capacity screen (FCS) assessed #184 in need of physical assistance with Bathing, Dressing, Toileting, Transfers, Mobility, Medication and treatment management; with bladder incontinence; with impaired short term memory, impaired memory recall and decision making; usually understands usually understood for communication; with falls and unsteadiness, vision and hearing impairment; used a walker and a wheelchair. The 6/01/16 negotiated service agreement (NSA) documented physical assistance with bathing, dressing, toileting, incontinent care, ambulation, and transfers, facility to administer medications and encourage activities. The 6/01/16 Resident Care Plan documented staff assist with glucometer testing, insulin administration, wound care, assistance with ambulation and transfers, with bathing, with dressing/undressing. Nurse's Notes (NN) of medical record documented: 6/20/16 - 6:55pm - I arrive after phone call from aide that #184 had fallen... an abrasion on left outer eyebrow with swelling... medium purple bruise below this... mottled abrasion on left cheek... 6/25/16 - 9:00pm - Resident found on floor next to bed... sitting up...had two knots on back of head, one was bleeding and one abrasion on chin... vitals taken, Owner/Operator/RN	S3028		

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S3028	Continued From page 16 (registered nurse) notified... Medical record lacked an investigation to rule out potential neglect or abuse when a cognitively impaired Resident discovered on floor... had attempted to independently complete services that required physical assistance by staff (such as transfers, ambulation). #184 experienced unwitnessed falls, and sustained injuries. The medical record lacked evidence of a report to the Department. 8/11/16 - 7:45pm - took Resident to room... left with call light and instructed to call when finished... got up without calling and fell to floor... nurse assessed... two skin tears... 8/30/16 - 9:00am - on floor rolled in a ball with blanket over... staff reports could of been there less than 10 minutes... assessed with no bruising, bumps, tears... unable to tell nurse the day, where he/she is at, who staff is... transport to hospital... Medical record lacked an investigation to rule out potential neglect when a cognitively impaired Resident on floor who was to be assisted with all transfers, mobility, and toileting. The medical record lacked evidence of a report to the Department. (Per Incident Report not found in NN) - 10/08/16 - 7:40pm - staff not in the room... heard a noise... found on floor between bed and table... nurse to assess... right arm skin tear... (Per Incident Report not found in NN) - 11/09/16 - 10:30am - heard chair alarm going off... went to check, found on floor on side, reaching for alarm to shut off...	S3028		

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S3028	Continued From page 17 (Per Incident Report not found in NN) - 11/14/16 - 3:30pm - got up without calling and fell over backwards... lost glasses but did not hit anything... no witness, alarm in chair had been messed with... 11/15/16 - 6:30pm - got up without calling and fell in the walk way of bathroom and room... was directed to call when done... at 10:15am went to see physician due to recent falls and continued neck pain... at 11:50am physician talked to nurse... has a spinous process fracture of C4 (cervical vertebrae)... unknown age... ordering PT (physical therapy) for pain... no need to wear a neck collar... 11/16/16 - 7:30am - Resident being assisted to bathroom... was washing hands... when done went for walker and lost balance... aide tried to assist, but fell... aide stated was right outside door and looked away for just a second then #184 fell... Resident sent to hospital... 10:00am...admitted... Medical record lacked an investigation to rule out potential neglect when a cognitively impaired Resident on floor who was to be assisted with all transfers, mobility, and toileting. The medical record lacked evidence of a report to the Department. On 3/02/17 at 9:45am Owner/Operator/RN (registered nurse) confirmed #184 was to have physical assistance with transfers and cares... confirmed no investigations completed for these unwitnessed falls and injuries. The Operator failed to report potential neglect or abuse of #184 to the department within 24 hours,	S3028		

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S3028	Continued From page 18 failed to thoroughly investigate allegations of potential neglect or abuse, and failed to maintain a written record of investigations.	S3028		
S3085 SS=F	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a) The census equalled 10 the sample included 3 Residents with two focused reviews completed. Based on reviews of record, and interviews, for three of three sampled (#189, #187, and #185) and for two of two focused reviews (#184 and #186) the Operator failed to ensure the Negotiated Service Agreement/Health Service Plan (NSA/HSP) contained a description of the	S3085		

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S3085	Continued From page 19 services the Resident to receive. Findings included: - Review of record revealed #184 admitted to facility 3/28/16 with diagnoses of Hypertension, Diabetes, Left leg wound, Cellulitis, Congestive heart failure, Anemia, Hyponatremia, and Left knee replacement. The 6/01/16 functional capacity screen (FCS) assessed #184 in need of physical assistance with bathing, dressing, toileting, transfers, mobility, medication and treatment management; with bladder incontinence; with impaired short term memory, impaired memory recall and decision making; usually understands usually understood for communication; with falls and unsteadiness, vision and hearing impairment; used a walker and a wheelchair. The 6/01/16 negotiated service agreement (NSA) documented physical assistance with bathing, dressing, toileting, incontinent care, ambulation, and transfers, facility to administer medications and encourage activities. The 6/01/16 Resident Care Plan documented staff assist with glucometer testing, insulin administration, wound care, assistance with ambulation and transfers, with bathing, with dressing/undressing. Nurses' Notes (NN) and Incident reports recorded falls on 6/20/16, 6/25/16, 8/11/16, 8/30/16, 10/08/16, 11/09/16, 11/14/16, 11/15/16, and 11/16/16. The NN and Incident reports documented the use of chair alarms. The NSA and HSP failed to include a description	S3085		

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S3085	Continued From page 20	S3085		

of service for a chair alarm, and failed to include a description of services to address falls or fall prevention.

On 3/02/17 at 9:45am Owner/Operator/RN (registered nurse) stated we did try other interventions with him/her... was defiant... we added the chair alarm sometime in summer... confirmed the NSA for #184 lacked chair alarm use and fall prevention interventions/revisions to address repeated falls.

The Operator failed to ensure the development of a written NSA/HSP for #184 that included a description of the services related to the use of a chair alarm and fall prevention.

- Review of record revealed #185 admitted 12/02/16 with diagnoses of Diabetes, Hypertension, Chronic kidney disease, Diastolic heart failure, Presbycusis, Retinopathy, Coronary artery disease, Anemia, Gout, and Intellectual functioning disability.

The current functional capacity screen (FCS) 12/02/16 assessed #185 in need of physical assistance with bathing, dressing, toileting, transfer, mobility, medication and treatment management; with bladder incontinence; with short term and long term memory impairment, memory recall impairment, decision making impairment; with falls, unsteadiness, vision and hearing impairments; used walker and wheelchair.

The medical record contained an 02/03/17 physician's order for "low salt diet."

The NSA of 12/02/16 recorded "regular diet." The

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S3085	Continued From page 21 NSA lacked a description of the services the Resident to receive for a therapeutic diet. On 3/02/17 at 12:40pm, Owner/Operator/RN (registered nurse) confirmed the NSA lacked a description of the dietary services to be provided. The Operator failed to ensure the development of a written NSA/HSP for #185 that included a description of the services related to a therapeutic low salt diet. - Review of record revealed #186 admitted to facility 11/10/16 with diagnoses of Fracture of right hip with pneumonia, Atrial fibrillation, Diabetes, Hypertension, Congestive heart failure, Renal failure, Breast cancer, Macular degeneration, and Anemia. The current 11/10/16 FCS assessed #186 in need of physical assistance with bathing, dressing, toileting, transfers, mobility, medication and treatment management; supervision with eating; with bladder incontinence; with impaired short term and long term memory, impaired memory recall and decision making; usually understandable and sometimes understands for communication; with falls and unsteadiness, vision impairment; used a walker. The 11/10/16 negotiated service agreement (NSA) lacked bathing services. The 11/10/16 Resident Care Plan documented staff assist with bathing after done with home health. The Care Plan and the medical record lacked documentation of when or if Resident received bathing services.	S3085		

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S3085	Continued From page 22 On 3/02/17 at 11:02am, Owner/Operator/RN (registered nurse) stated when Home Health comes in, they automatically do some of the bathing and we do some... confirmed bathing service, who, when, not addressed on the NSA... confirmed no documentation in facility of when Home Health had actually provided that service... would have to get copies from them. The Operator failed to ensure the development of a written NSA/HSP for #186 that included a description of the services related to bathing. - Review of record revealed #189 admitted to facility 11/07/16 with diagnoses of Cerebrovascular accident, Pacemaker, Breast cancer, Depression, Diabetes, Atrial fibrillation, Osteoporosis, Dementia, Microvascular disease, Hypertension, and Recent fracture of right humerus. The current 11/07/16 functional capacity screen (FCS) assessed #189 in need of physical assistance with bathing, dressing, toileting, transfers, mobility, medication and treatment management; supervision with eating; with bladder incontinence, short term and long term memory impairment, decision making and memory recall impairment; with falls/unsteadiness, vision and hearing impairments; used a walker and wheelchair; used CPAP (continuous positive airway pressure) at night, and had pacemaker. The medical record contained a physician's consent for self administration of Australian Dream and Refresh eye drops, the medication administration record documented Resident maintained medication at bedside for self	S3085		

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S3085	Continued From page 23 administration. The 1/07/16 negotiated service agreement (NSA) lacked bathing services and lacked interventions regarding pacemaker maintenance or checks. The NSA lacked information related to medication self administration of select medications. By interview on 3/02/17 at 11:35am, Owner/Operator/RN (registered nurse) confirmed the NSA lacked bathing, pacemaker interventions, and self administration of select medications. The Operator failed to ensure the development of a written NSA/HSP for #189 that included a description of the services related to bathing, pacemaker monitoring, and self administration of select medications. - Review of record revealed #187 admitted to facility 01/19/16 with diagnoses of Renal failure, Gastroesophageal reflux disease, Hypertension, Bout, Depression, Anxiety, Frequent stasis ulcers, Esophageal stricture, Forgetfulness, and Anemia. The current FCS of 01/19/17 assessed #187 in need of physical assistance with bathing, medication and treatment management, bladder incontinence, short term memory impairment, memory recall impairment, and decision making impairment; used a walker and a lift chair. The FCS therapies and treatments identified "ambulate three times daily in halls 25 yards"as a need. The medical record contained a self administration assessment completed 01/19/17	S3085		

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S3085	Continued From page 24 for Tums, Calmoseptine, and Saline nasal spray. The 01/19/17 negotiated service agreement (NSA) failed to specify Resident self administered select medication. The NSA failed to include the service of ambulation three times daily 25 yards. By interview on 3/02/17 at 12:37pm, Owner/Operator/RN (registered nurse) confirmed the ambulation directive and the self administration of select medications not included on the NSA. The Operator failed to ensure the development of a written NSA/HSP for #187 that included a description of the services related to self administration of select medications and therapeutic walking of 25 yards three times daily.	S3085		
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 census equalled 10 the sample included three Residents with two focused reviews	S3155		

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completed. Based on interview and review of record, for one of three sampled (#189) and for one of two focused reviews (#184), the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of each resident in accordance with the functional capacity screening (FCS) and the negotiated service agreement (NSA).

Findings included:

- Review of record revealed #189 admitted to facility 11/07/16 with diagnoses of Cerebrovascular accident, Breast cancer, Depression, Diabetes, Atrial fibrillation, Osteoporosis, Dementia, Microvascular disease, Hypertension, and Recent fracture of right humerus.

The current 11/07/16 functional capacity screen (FCS) assessed #189 in need of physical assistance with Bathing, Dressing, Toileting, Transfers, Mobility, Medication and treatment management; supervision with eating; with bladder incontinence, short term and long term memory impairment, decision making and memory recall impairment; with falls/unsteadiness, vision and hearing impairments; used a walker and wheelchair.

The 1/07/16 negotiated service agreement (NSA) documented physical assistance with dressing, toileting, incontinent care, ambulation, and transfers, facility to administer medications and encourage activities.

The 11/07/16 Resident Care Plan documented staff assist with dressing, undressing, toileting, changing briefs, assist with all transfers and

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ambulation; staff to walk with using gait belt and walker; make sure has call light at all times and remind to call for assistance; check on frequently day and night.

By observation on 02/28/17 at 2:30pm, in the open nurse desk area attached to the south dining room and hallway of facility, a video screen approximately five inches by eight inches sat on a horizontal shelf above the nurses' desk. On display, a Resident (#189) sitting in a recliner watching TV in his/her room. No staff at desk at time of this observation.

Nurse ' s Notes of medical record documented: 11/30/16 - 935 - Resident fell in room... did not use call light... decided to go to bathroom and must of turned wrong and fell to floor... has rug burn on right elbow... denies pain... instructed to use call light

The NSA lacked any revisions or additional interventions to address the Resident's attempt to complete transfers, mobility, and toileting independently when assessed as needing staff assistance for these.

02/05/17 - 5:00am - Resident checked at 5am... sitting at side of bed and states fell out of bed... #189's right hand is purple and swollen, sent to ER (emergency room).

02/05/17 - 8:45am - returned from ER with splint on fingers... too swollen to put cast on... also has urinary tract infection... will start Cipro...

The NSA lacked any revisions or additional interventions to address the Resident's attempt to complete transfers when assessed as needing staff assistance for transfers.

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S3155	Continued From page 27 On 02/28/17 at 3:20pm from doorway of #189's room, observed #189 preparing to stand up from recliner unassisted. Call light cord observed laying across bed and within reach of Resident, note attached to wall above bed with statement reminding Resident to call for help before getting up. By interview on 3/02/17 at 12:10pm, Owner/Operator/RN (registered nurse) confirmed the visual monitor not effective in preventing Resident falls... confirmed the NSA not reviewed or revised to address the independent attempts by Resident that resulted in falls and injuries. The Operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of #189 in regard to the identification of need for transfer, mobility, and toileting assistance for fall prevention measures. - Review of record revealed #184 admitted to facility 3/28/16 with diagnoses of Hypertension, Diabetes, Left leg wound, Cellulitis, Congestive heart failure, Anemia, Hyponatremia, and Left knee replacement. The 6/01/16 functional capacity screen (FCS) assessed #184 in need of physical assistance with Bathing, Dressing, Toileting, Transfers, Mobility, Medication and treatment management; with bladder incontinence; with impaired short term memory, impaired memory recall and decision making; usually understands usually understood for communication; with falls and unsteadiness, vision and hearing impairment; used a walker and a wheelchair.	S3155		

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S3155	Continued From page 28 The 6/01/16 negotiated service agreement (NSA) documented physical assistance with bathing, dressing, toileting, incontinent care, ambulation, and transfers, facility to administer medications and encourage activities. The 6/01/16 Resident Care Plan documented staff assist with glucometer testing, insulin administration, wound care, assistance with ambulation and transfers, with bathing, with dressing/undressing. Nurse's Notes (NN) of medical record documented: 6/20/16 - 6:55pm - I arrive after phone call from aide that #184 had fallen... an abrasion on left outer eyebrow with swelling... medium purple bruise below this... mottled abrasion on left cheek... 6/25/16 - 9:00pm - Resident found on floor next to bed... sitting up...had two knots on back of head, one was bleeding and one abrasion on chin... vitals taken, Owner/Operator/RN (registered nurse) notified... 8/11/16 - 7:45pm - took Resident to room... left with call light and instructed to call when finished... got up without calling and fell to floor... nurse assessed... two skin tears... 8/30/16 - 9:00am - on floor rolled in a ball with blanket over... staff reports could of been there less than 10 minutes... assessed with no bruising, bumps, tears... unable to tell nurse the day, where he/she is at, who staff is... transport to hospital... (Per Incident Report not found in NN) - 10/08/16 -	S3155		

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S3155	Continued From page 29 7:40pm - staff not in the room... heard a noise... found on floor between bed and table... nurse to assess... right arm skin tear... (Per Incident Report not found in NN) - 11/09/16 - 10:30am - heard chair alarm going off... went to check, found on floor on side, reaching for alarm to shut off... (Per Incident Report not found in NN) - 11/14/16 - 3:30pm - got up without calling and fell over backwards... lost glasses but did not hit anything... no witness, alarm in chair had been messed with... 11/15/16 - 6:30pm - got up without calling and fell in the walk way of bathroom and room... was directed to call when done... at 10:15am went to see physician due to recent falls and continued neck pain... at 11:50am physician talked to nurse... has a spinous process fracture of C4 (cervical vertebrae)... unknown age... ordering PT (physical therapy) for pain... no need to wear a neck collar... 11/16/16 - 7:30am - Resident being assisted to bathroom... was washing hands... when done went for walker and lost balance... aide tried to assist, but fell... aide stated was right outside door and looked away for just a second then #184 fell... Resident sent to hospital... 10:00am...admitted... The NSA lacked any revisions or additional interventions between 6/01/16 and 11/16/16 to address the Resident's attempt to complete activities of daily living independently when assessed as needing staff assistance for these. On 3/02/17 at 9:45am Owner/Operator/RN	S3155		

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S3155	Continued From page 30 (registered nurse) confirmed #184 was to have physical assistance with transfers and cares... confirmed no NSA revisions completed to address repetitive falls and injuries. The Operator failed to report potential neglect or abuse of #184 to the department within 24 hours, failed to thoroughly investigate allegations of potential neglect or abuse, and failed to maintain a written record of investigations.	S3155		
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 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 census equalled 10 the sample included six	S3175		

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S3175	Continued From page 31 Residents, with two focused reviews completed. The facility identified no Residents who self administered medications. Based on interview and review of record, for one of three sampled who self administered medications (#189), the Operator failed to ensure a licensed nurse performed an assessment of the Resident's ability to safely and accurately self administer medications. Findings included: - Review of record revealed #189 admitted to facility 11/07/16 with diagnoses of Cerebrovascular accident, Breast cancer, Depression, Diabetes, Atrial fibrillation, Osteoporosis, Dementia, Microvascular disease, Hypertension, and Recent fracture of right humerus. The current 11/07/16 functional capacity screen (FCS) assessed #189 in need of physical assistance with Bathing, Dressing, Toileting, Transfers, Mobility, Medication and treatment management; with bladder incontinence, short term and long term memory impairment, decision making and memory recall impairment, with falls/unsteadiness, vision and hearing impairments; used a walker and wheelchair. The current 11/07/16 negotiated service agreement (NSA) documented facility to provide medication management. The medical record contained a "Fax Physician's Order Sheet" dated 11/08/16: #189 has Refresh tears and puts one drop in both eyes daily at HS (bed time). Has Australian Dream Arthritis pain relief cream that he/she uses and HS on hands. I feel comfortable letting him/her have this at	S3175		

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S3175	Continued From page 32 bedside to self administer if it's ok with you. The physician responded "ok". The current February 2017 MAR (medication administration record) contained a note "Arthritis dream... may leave in room and self administer." The MAR of February 2017 documented facility staff now administering Refresh tears at HS. The medical record lacked a self administration assessment. The Operator failed to ensure a licensed nurse conducted a self administration assessment of #185 prior to #185 self administering medications.	S3175		
S3215 SS=D	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	S3215		

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S3215	Continued From page 33 medications in a place that is accessible only to the resident, licensed nurses, and medication 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) The census equalled 10 the sample included three Residents, and two focused reviews completed. The roster identified one Resident who used insulin and this Resident included in the sample. Based on observation, interview, and review of record, for one of one sampled (#185) and for all non-sampled who used insulin, the licensed nurses and medication aides failed to ensure insulin pens stored in accordance with manufacturer's recommendations. Findings included: - By observation on 02/28/17 at 2:45pm in the medication storage room of facility, licensed nurses and medication aides stored in use insulin pens in the refrigerator of the medication storage area. The refrigerator contained locked metal boxes, one with prescription boxes of insulin pens inside. This locked, refrigerated box also contained two in use insulin pens, one Novolog	S3215		

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S3215	Continued From page 34 and one Lantus pen. The pens contained the date opened or put into use. On 02/28/17 at 2:45pm, Certified Medication Aide (CMA) #B and CMA #C stated neither one aware of the need to store in use insulin pens outside the refrigerator. Staff confirmed we have always stored the insulin pens in refrigerator. Review of package inserts revealed in each case the manufacturer recommended refrigeration of pens until open, and then storage of pens at room temperature until discard date. By review of facility Medication policy and procedure, there was no mention of insulin pen storage. On 3/02/17 at 11:54am Owner/Operator/RN (registered nurse) confirmed the facility policy for medication storage specified "all drugs... shall be stored... following the manufacturers recommendations..." The licensed nurses and medication aides failed to ensure for #185, and any Resident with insulin pens, the pens stored in accordance with manufacturer's recommendations.	S3215		
S3261 SS=D	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	S3261		

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S3261	Continued From page 35 by: KAR 26-41-105(f) The census equalled 10 the sample included three Residents and two focused reviews completed. Based on interviews, and review of records, for one of three sampled (#186), the Operator failed to ensure each Resident record contained 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. Findings included: - Review of record revealed #186 admitted to facility 11/10/16 with diagnoses of Fracture of right hip with pneumonia, Atrial fibrillation, Diabetes, Hypertension, Congestive heart failure, Renal failure, Breast cancer, Macular degeneration, and Anemia. The current 11/10/16 FCS assessed #186 in need of physical assistance with Bathing, Dressing, Toileting, Transfers, Mobility, Medication and treatment management; supervision with eating; with bladder incontinence; with impaired short term and long term memory, impaired memory recall and decision making; usually understandable and sometimes understands for communication; with falls and unsteadiness, vision impairment; used a walker. The 11/10/16 negotiated service agreement (NSA) documented physical assistance with dressing, toileting, incontinent care, ambulation, and transfers, facility to administer medications and encourage activities. PRN (as needed) MAR's (medication	S3261		

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S3261	Continued From page 36	S3261		

administration records) of November and December 2016 documented:
Tylenol (analgesic for pain or fever) 58 doses administered
Norco (narcotic pain medication) 13 doses administered
Ativan (anti-anxiety medication) 11 doses administered
Antacid (for upset stomach and acid indigestion) one dose administered

The pages included columns "date", "time", "medication and dose", "reason given", "results", "signature".
Ten of the "results" spaces remained empty with nothing documented for effectiveness of the medication.
32 of the "results" noted simply "asleep."
Seven of the "results" noted "no complaints."

On 11/13/16, 11/14/16, 11/17/16, 11/27/16 five doses of Tylenol 650mg (milligrams) administered for "heel pain" documented results as "no relief."
The Nurses' Notes (NN) lacked any entries between 11/10/16 and 11/22/16, and between 11/22/16 and 11/30/16. The record contained no documentation of actions taken to treat the unresolved pain, or the results of the actions taken. The record lacked an assessment of the symptoms, or alternatives besides medications attempted.

Medication "results"
on 12/01/16 for Tylenol noted as "still uncomfortable";
on 12/05/16, 12/28/16, 12/29/16, and 12/31/16 for Norco noted as "still hurts";
on 12/08/16 for Tylenol noted as "not helping";
on 12/21/16, 12/28/16, 12/29/16, and 12/30/16 for Ativan noted as "still anxious";

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S3261	Continued From page 37 on 12/29/16, 12/30/16, and 01/01/16 for Tylenol as still elevated temperature. The NN for these administration times and dates also lacked documentation of an assessment of the symptoms, other attempted alternatives for the ineffective PRN medications, actions taken, and results of the actions. By interview on 3/02/16 at 11:02am, Owner/Operator/RN (registered nurse) stated the CMA's (certified medication aides call me every time they give a PRN medication... then I initial the medication... confirmed no documentation in medical record of an assessment or steps taken when medications not effective... confirmed no actions taken or results of the actions noted. The Operator failed to ensure #186's record contained 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.	S3261		
S3290 SS=E	26-41-206 (a) (b) Dietary Services (a) Provision of dietary services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. If the administrator or operator of the facility establishes a contract with another entity to provide or coordinate the provision of dietary services to the residents, the administrator or operator shall ensure that entity ' s compliance with these regulations. (b) Staff. The supervisory responsibility for dietetic services shall be assigned to one	S3290		

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S3290	Continued From page 38 employee. (1) A dietetic services supervisor or licensed dietician shall provide scheduled on-site supervision in each facility with 11 or more residents. (2) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(a)(b) The census equalled 10 the sample included three Residents, with two focused reviews completed. The facility identified all Resident with meal service. Based on interview and review of record, for two of three sampled with therapeautic diets, (#187 and #185), the Operator failed to ensure the diets prepared according to instructions from a medical care provider or licensed dietitian. Findings included: - Review of record revealed #185 admitted 12/02/16 with diagnoses of Diabetes, Hypertension, Chronic kidney disease, Diastolic heart failure, Presbycusis, Retinopathy, Coronary artery disease, Anemia, Gout, and Intellectual functioning disability. The current functional capacity screen (FCS)	S3290		

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S3290	Continued From page 39 12/02/16 assessed #185 in need of physical assistance with bathing, dressing, toileting, transfer, mobility, medication and treatment management; with bladder incontinencen; with short term and long term memory impairment, memory recall impairment, decision making impairment; with falls, unsteadiness, vision and hearing impairments; used walker and wheelchair. The medical record contained an 02/03/17 physician's order for "low salt diet." The negotiated service agreement (NSA) of 12/02/16 "regular diet." - Review of record revealed #187 admitted to facility 01/19/16 with diagnoses of Renal failure, Gastroesophageal reflux disease, Hypertension, Bout, Depression, Anxiety, Frequent stasis ulcers, Esophageal stricture, Forgetfulness, and Anemia. The current FCS of 01/19/17 assessed #187 in need of physical assistance with bathing, medication and treatment management, bladder incontinence, short term memory impairment, memory recall impairment, and decision making impairment; used a walker and a lift chair. The previous FCS of 6/30/16 coded the same, with the addition of supervision for mobility. The medical record contained a physician's order for "Lo NA (sodium) diet" dated 01/20/16. The 8/01/16 Resident Care Plan documented "difficulty swallowing secondary to esophageal strictures, grind meat... cut up other meat/food into small bites." The medical record lacked a physician's order for mechanically altering #187's	S3290		

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S3290	Continued From page 40 food. The 01/19/17 negotiated service agreement (NSA) documented "low salt diet." - By interview on 3/02/17 at 10:30am, Owner/Operator/RN (registered nurse) confirmed no written preparation directions from a medical care provider or dietician for the therapeautic diets of Low Sodium and Mechanically Altered. The Operator failed to ensure the therapeautic order diets for #187 and #185 prepared according to instructions from a medical care provider or licensed dietitian.	S3290		