STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023009A	A. BUILDING: _____ B. WING _____	01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with a complaint #173424 at the above named Assisted Living, conducted on 01/23/23, 01/24/23 and 01/25/23.	S 000		
S3155 SS=D	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 40 residents. The sample included three residents. Based on observation, interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for one of three sampled residents evidenced by the failure to complete and document an assessment for the purpose to use bed rails, ability to use bed rails safely without risk of entrapment, and to confirm the bed rails were not a restraint for resident R101.	S3155		

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

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S3155	Continued From page 1	S3155		

Findings included:

- R101's medical record revealed the resident moved into the facility on 01/24/20 with a diagnosis of dementia.

The 01/09/23 "Functional Capacity Screen" (FCS) documented R101 required total assist with transfers.

The 01/24/23 "Negotiated Service Agreement" (NSA) documented staff provided total assist with transfers and used a sit-to-stand lift. The NSA did not identify R101 used a bed rail.

Review of R101's medical records failed to locate documentation of a bed rail assessment being completed.

On 01/24/23 at 03:50 PM observation of R101's room revealed a low bed with quarter rails attached to the bed in the lowered position.

On 01/24/23 at 03:43 PM Certified Medication Aide (CMA) I stated R101 used a bed when he was in bed.

On 01/24/23 at 10:40 AM Administrative Nurse B stated she did not complete a bed-safety rail assessment for R101.

The 04/02/07 "Bed-Safety Guidelines" policy documented, "Prior to utilization ...of any Bed-Safety Rail or Device, a risk review will be conducted ...by a designated qualified healthcare professional on admission, re-admission, or with a change in status to evaluate the need for a Bed-Safety Device ...The resident's plan of care

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S3155	Continued From page 2 must be updated to reflect goals and interventions relative to the use of Bed-Safety Rails and Devices." The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for R101 regarding the use of a bed assistive device.	S3155		
S3165 SS=F	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility reported a census of 40 residents with three residents included in the sample. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) identified the licensed nurse responsible for the implementation and supervision of the health care services plan for residents (R)101, R102 and R103. Findings included: - R101's medical record revealed the resident moved into the facility on 01/24/20 with a	S3165		

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S3165	Continued From page 3	S3165		

diagnosis of dementia.

R101's most recent NSA was completed on 01/24/23 and did not identify the nurse responsible for the implementation and supervision of the Health Care Service Plan (HCSP).

On 01/24/23 at 12:08 PM Administrative Nurse B stated she did not include the nurse responsible for the implementation and supervision of the health care services plan in R101's NSA.

The operator failed to ensure the NSA identified the licensed nurse responsible for the implementation and supervision of the health care services plan for R101.

- R102's medical record revealed the resident moved into the facility on 08/28/21 with a diagnosis of dementia.

R102's most recent NSA was completed on 05/16/22 and did not identify the nurse responsible for the implementation and supervision of the HCSP.

On 01/24/23 at 12:08 PM Administrative Nurse B stated she did not include the nurse responsible for the implementation and supervision of the health care services plan in R102's NSA.

The operator failed to ensure the NSA identified the licensed nurse responsible for the implementation and supervision of the health care services plan for R102.

- R103's medical record revealed the resident

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S3165	Continued From page 4 moved into the facility on 01/20/23 with a diagnosis of weakness. R103's most recent NSA was completed on 01/24/23 and did not identify the nurse responsible for the implementation and supervision of the HCSP. On 01/24/23 at 12:08 PM Administrative Nurse B stated she did not include the nurse responsible for the implementation and supervision of the health care services plan in R103's NSA. The operator failed to ensure the NSA identified the licensed nurse responsible for the implementation and supervision of the health care services plan for R103.	S3165		
S3211 SS=F	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	S3211		

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S3211	Continued From page 5 by: KAR 26-41-205 (g)(3) The facility reported a census of 40 residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of over the counter (OTC) medications for five residents and failed to ensure no "stock meds" unassigned to residents were used. Findings included: - Observation on 01/23/23 at 03:22 PM revealed the facility's third floor assisted living medication cart contained the following OTC medications which were not labeled with a resident's full name: Resident (R)104: One bottle of Calcium 6oo milligrams (mg) R105: One bottle of Tylenol 8 hour Arthritis Pain Medications labeled as "Stock Meds": One bottle of Equate Extra Strength pain reliever One bottle of GeriCare Regular Strength 325 mg Acetaminophen One bottle of CVS Health Allergy Relief One bottle of GeriCare Extra Strength 500 mg Acetaminophen One bottle of Aleve One box of Good Neighbor Pharmacy Anti-Diarrhea	S3211		

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S3211	Continued From page 6 The third floor assisted living treatment cart contained the following OTC medications which were not labeled with a resident's full name: R106: One bottle of MiraLAX R104: One bottle of Centrum Silver Women Multivitamin/Multimineral One bottle of Equate Allergy Relief One bottle of Nature Made B12 One bottle of Equate Pain Reliever One bottle of Kroger Allergy Two bottles of MiraLAX R107: One bottle of Nature Made B-Complex R108: One bottle of Equate Ibuprofen The memory care unit medication cart contained the following OTC medications which were not labeled with a resident's full name: One bottle of CVS Health Acetaminophen Two bottles of Regular Strength Acetaminophen One bottle of Equate Extra Strength Pain Reliever 500 caplets One bottle of GeriCare Extra Strength The operator failed to ensure all OTC medications were labeled by a pharmacist or licensed nurse with the resident's full name.	S3211		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff	S3248		

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S3248	Continued From page 7 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 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) The facility reported a census of 40 residents. Based on interview and record review, the operator failed to ensure two of four newly hired employees records included evidence of timely verification with the nurse aide registry was completed.	S3248		

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S3248	Continued From page 8 Findings included: - Review of employee files conducted on 01/24/23 revealed the following: Certified Medication Aide (CMA) C hired on 12/28/22. The "Nurse Aide Registry Confirmation Notice" did not have a date to indicate when the background check was completed for this staff. Certified Nurse Aide (CNA) D hired on 09/12/22. The "Nurse Aide Registry Confirmation Notice" did not have a date to indicate when the background check was completed for this staff. On 01/24/23 at 11:10 AM Administrative Staff E acknowledged the Kansas Nurse Aide Registry Confirmation sheets did not have dates printed on them to show when the nurse aide registry was checked. The operator failed to ensure timely verifications of the nurse aide registry checks were completed.	S3248		
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 by:	S3261		

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S3261	Continued From page 9 KAR 26-41-105(f)(11) The facility reported a census of 40 residents. The sample included three residents. Based on interview and record review the operator failed to ensure one of three sampled residents (R)101's record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, action taken, and results of the action concerning pressure wounds. Findings included: - R101's medical record revealed the resident moved into the facility on 01/24/20 with a diagnosis of dementia. The 01/09/23 "Functional Capacity Screen" (FCS) documented R101 required total assist with transfers. The 01/24/23 "Negotiated Service Agreement/Health Service Plan" (NSA/HSP) documented, "Caregivers and hospice will observe/document/report location, size and treatment of skin injury." Review of R101's medical records failed to locate documentation of pressure wound onset, location, and measurements of pressure wounds. Order dated 01/03/23 to cleanse bilateral buttocks with wound cleanser, pat dry apply thera- honey and cover with Optifoam (bordered dressing) and secure with skin prep, daily and as needed by facility.	S3261		

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S3261	Continued From page 10 The 01/09/22 and 01/12/23 "Senior Living Resident Evaluation" lacked documentation under the "Skin Integrity" portion of the assessment. On 01/24/23 at 10:40 AM Administrative Nurse B confirmed she did not document wound measurements for R101 and stated hospice documented the wound care provided in their own records but did not include documentation in the facility medical records for R101. On 01/25/23 the facility provided a policy for "Pressure Wounds" but it did not address documentation of wound measurements and treatments. The operator failed to ensure designated staff included documentation of all incidents, symptoms and other indications of illness or injury including the dated, time of occurrence, action taken, and results of the action for R101 concerning pressure wounds.	S3261		
S3270 SS=F	26-41-104 (b) Written Emergency Plan (b) Each administrator or operator shall ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including the following: (1) Fire; (2) flood; (3) severe weather; (4) tornado; (5) explosion; (6) natural gas leak;	S3270		

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S3270	Continued From page 11 (7) lack of electrical or water service; (8) missing residents; and (9) any other potential emergency situations. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(b)(5) The facility reported a census of 40 residents. Based on record review and interview for all residents and all facility employees, the operator failed to ensure the disaster and emergency plan include all required items as it failed to include information on explosion. Findings included: - On 01/24/23 review of documentation of the emergency management plan revealed it did not include information concerning explosions. On 01/24/23 at 09:25 AM Administrative Staff A stated she couldn't find where the emergency management plan included information on explosions. The operator failed to ensure the emergency management plan included all the required items.	S3270		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by	S3280		

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S3280	Continued From page 12 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)(4) The facility reported a census of 40 residents. Based on record review and interview for all residents and all facility employees, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with residents. Findings included: - On 01/24/23 Administrative Staff A provided documentation of meetings with residents that included limited review of the emergency management plan. These reviews did not include all eight required items and the	S3280		

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S3280	Continued From page 13 emergency management plan did not include information about explosion. These reviews did not indicate how many residents were present during the review and if all residents took part in this review. On 01/24/23 at 09:25 AM Administrative Staff A stated she they did not have quarterly reviews with residents concerning all eight required topics to cover in the emergency management plan. The operator failed to ensure the performance of quarterly reviews of the emergency management plan with residents.	S3280		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by:	S3310		

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S3310	Continued From page 14 KAR 26-41-207(c) The facility reported a census of 40 residents. Based on interview and record review for three residents and five new employee records, the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This failure effected all residents who lived in the assisted living facility. Findings included: - Resident (R)101 moved into the facility on 01/24/20 with a diagnosis of dementia. Review of R101's medical record lacked evidence the resident had an annual TB symptom screen questionnaire completed. On 01/24/23 at 02:49 PM Administrative Nurse B stated it was their policy not to complete an annual TB symptom questionnaire. The 06/2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each resident ...shall have an annual TB symptom screen." The operator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. - R102 moved into the facility on 08/28/21 with a diagnosis of dementia.	S3310		

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S3310	Continued From page 15 Review of R102's medical record lacked evidence the resident had an annual TB symptom screen questionnaire completed. On 01/24/23 at 02:50 PM Administrative Nurse B stated it was their policy not to complete an annual TB symptom questionnaire. The 06/2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each resident ...shall have an annual TB symptom screen." The operator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. - Review of five newly hired employee files revealed the following: Review of facility personnel records revealed: Certified Nurse Aide (CNA) F was hired on 10/05/22 and lacked evidence a TB symptom screen questionnaire and the second step of the two-step TB skin test (TST) was completed. Certified Medication Aide (CMA) C was hired on 12/28/22 and lacked evidence a TB symptom screen questionnaire was completed. CNA D was hired on 09/12/22 and lacked evidence a two-step TST was completed. Dietary Staff G was hired on 10/12/22 and lacked evidence the second step of the TST was completed. The 06/2013 "Tuberculosis (TB) Guidelines for	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023009A	A. BUILDING: _____ B. WING _____	01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

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S3310	Continued From page 16 Adult Care Homes" documented, "Each ...new employee shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within 7 days of ...employment ...Each new ...employee shall receive a two-step TST ...within 7 days of ...employment ..." For four of five new employee record reviewed, 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.	S3310		