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BROOKDALE SHAWNEE	11400 W 65TH STREET SHAWNEE, KS 66203

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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaint #196898, 196877, 196852, 193038, 191830, 191604, 190373, 188693, 188512, 187560, 185567 at the above named assisted living conducted on 08/25/25, 08/26/2025, 08/27/25, 08/28/25.	S 000		
S3026 SS=H	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 30 residents with three included in the sample and eight focused reviews. Based on observation, interview and record review the administrator failed to protect five residents from neglect which resulted in harm by the failure to ensure facility licensed staff provided timely nursing skin assessments, documentation of skin wounds, and coordinated plans of care. Resident (R) 1 and R3 developed facility acquired pressure ulcers. R6 developed a facility acquired skin excoriation on his buttocks that worsened until	S3026		

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

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he suffered daily declines for three days and went to the hospital for a possible abscess on his right buttock and infection in his bloodstream. R7 suffered more than one facility acquired skin infection that required antibiotic treatment and developed a foot pressure ulcer. He transferred to the hospital for treatment of signs and symptoms of a blood infection. R9 suffered a sudden onset open wound on her buttocks that required transport to the hospital for treatment.

Findings included:

- Review of R1's record revealed an admission date of 03/01/25 with diagnoses of Alzheimer's Disease and degenerative disease of nervous system.

The 04/28/25 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with bathing, dressing, toileting and eating. She was unable to perform transfers and management of medications and treatments. R1 was frequently incontinent of bladder, was sometimes understandable and usually understood others during communication. She had short term, long term, memory recall and impaired decision-making cognitive difficulties.

The 04/28/25 "Negotiated Service Agreement" (NSA) identified facility staff provided R1 physical assistance with bathing, dressing, and toileting. Two staff provided assistance with a mechanical lift for transfers, physical assistance with walking/mobility and staff managed medications and treatments. She had difficulty during communication with finding words and

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finishing thoughts. Staff provided prompts and cues as needed. R1 had fragile, thin skin and staff encouraged her to communicate with medical staff as needed if she had any skin concerns. She had a small open area on the back of her right lower leg on 04/04/25. The NSA failed to describe services provided for eating, falls, skin and/or wound care, daily catheter care and failed to list the providers of the services.

The 08/26/25 "Skin Observation Form (Quarterly)" documented R1 had redness and open areas/wounds with a Braden Score (a tool used in healthcare to assess a person's risk of developing pressure ulcers) of "16 or less" which indicated "prevention strategies required."

Review of R1's nursing progress notes from 04/04/25 to 08/25/25 revealed the following:

The 04/21/25 "Alert Charting Note" documented R1's family expressed concerns about her declining status. The facility nurse notified the nurse practitioner and received orders for antibiotic therapy. The note lacked evidence of documentation R1 received an assessment by a licensed nurse and description of how her status had declined.

The 04/22/25 "Transfer Out to Hospital Note" documented R1 had a decline in level of consciousness with large painful abdomen, and faint bowel sounds. Paramedics arrived on site, placed an intravenous line, obtained vital signs, and administered oxygen via nasal cannula for shortness of air.

The 04/28/25 "Return from Hospital Note"

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documented R1 returned from the hospital with an indwelling urinary catheter for a urinary tract infection. A small, reddened area was on the left side of her coccyx, and she required assistance with a mechanical lift to transfer to bed. The note lacked evidence of documentation of size and characteristics of red area on left side of coccyx.

The 05/08/25 "Care Conference Note" documented a meeting occurred between R1's Durable Power of Attorney (DPOA) and Administrative Nurse C where they discussed R1's hospital visit, a blister on her heel, and redness on her left knee. The note lacked evidence of documentation of the location of the blister (right or left heel) and blister characteristics, including signs of infection, and size and characteristics of redness on R1's left knee, actions taken and results of the action.

The 05/09/25 "Skin Observation" sheet by Certified Nurse Aid (CNA) D reported a "sore" with a hand drawn circle around the coccyx area.

The 05/09/25 "Alert Charting Note" documented R1was on antibiotics for a urinary tract infection and a heel wound. The note lacked evidence of documentation of the location of the wound (right or left heel) including time of origin, size, odor, tissue characteristics including drainage, granulation), any signs of infection, and a plan for treatment.

The 05/11/25 "Alert Charting Note" documented R1 continued on alert charting for antibiotics for a left heel wound and urinary tract infection. The note lacked evidence of documentation of the left heel wound characteristics, including signs of

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S3026	Continued From page 4 infection, and size. Review of nursing progress notes from 05/09/25 (when direct-care staff informed the licensed nurse R1 had a sore on her coccyx area) through 05/11/25 lacked evidence of documentation of the coccyx wound including time of origin, size, characteristics, any signs of infection, and plan for treatment. The 05/17/25 "General Progress Note" documented R1 received left heel wound management by a home health provider and was on a routine turning schedule. The 05/20/25 "General Progress Note" R1 was admitted to hospice, an air mattress and wound care provided. The 06/24/25 skin observation sheet by unidentified CNA reported redness to lateral aspect of right ankle. Review of skin observation sheets from 06/24/25 to 08/22/25 revealed unidentified facility and/or hospice staff reported skin issues seven times on 06/24/25, 07/01/25, 07/08/25, 07/15/25, 07/18/25, 07/22/25, and 08/22/25. The nurse signature line on the 06/24/25, 06/27/25, 07/01/25, 07/08/25, 07/11/25, 07/18/25, 07/22/25, and 08/12/25 "Skin Observation Sheets" were left blank. Review of nursing progress notes from 06/24/25 to 08/22/25 lacked evidence of follow up documentation when direct-care staff observed and reported skin issues.	S3026		

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S3026	Continued From page 5 The 08/05/25 hospice "Skilled Nursing Visit" note documented R1 was consistently nonverbal with no orientation, was Hoyer lift dependent for transfers and continued to have multiple, poorly healing wounds to bilateral heels and coccyx. The 08/19/25 hospice "Narrative Note" documented that R1's "bottom" worsened. Hospice nurse educated facility staff of the need to offload R1 out of her reclining wheelchair and onto her side in bed often. The hospice nurse also updated and educated Administrative Nurse C who confirmed understanding. R1 was recorded as normal for her baseline, nonverbal, and chair bound. The 08/25/25 hospice "Narrative Note" documented patient brief soiled with bowel movement and hospice took R1 to room and cleaned bowel movement and the coccyx wound was cleaned and then barrier applied. The 08/27/25 hospice "Narrative Note" documented R1's wounds cleansed and dressed prior to placing patient in bed using Hoyer lift. R1's brief was found soiled with bowel movement, hospice staff cleaned R1's bowel movement and paste was applied. R1 offloaded in bed on left side by hospice staff. Review of R1's record from admission to 04/21/25 through 08/27/25 lacked evidence of documentation of skin monitoring and interventions to prevent pressure wounds by licensed facility staff prior to pressure wounds occurring, lacked evidence of documentation of the pressure wounds after they developed,	S3026		

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including time of origin, wound sizes (length, width, and depth), odor, tissue characteristics (including drainage, granulation), any signs of infection, and lacked a plan for treatment of the pressure wounds.

Observation on 08/28/25 at 09:12 AM revealed two staff changed R1 in bed. Her buttocks and coccyx wound appeared to have deep red tissue in a large circular area with several open areas scattered throughout the wound bed. Staff applied zinc oxide to wound area per direction of Administrative Nurse C. Staff assisted R1 onto her right side with a pillow between her knees, a pillow behind her back, and offloading boots on both feet. R1 remained unresponsive throughout the process. Staff completed cares and exited R1's room at 09:12 AM.

Observation of R1 continued from 09:12 AM through 11:22 AM (two hours and ten minutes) revealed no staff returned to provide services listed on NSA as follows: checked and change if needed and/or repositioned.

08/25/25 at 03:01 PM Administrative Nurse C confirmed that R1 had more than one wound managed by hospice.

On 08/28/25 at 11:25 AM Administrative Nurse C stated facility staff should be checking on R1 at least every two hours and "do what they need to do."

- Record review for R3 revealed an admission date of 07/15/21 with a diagnosis of dementia.

The 01/27/25 "FCS" revealed R3 required

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physical assistance with bathing, dressing and toileting. He was unable to perform transfers, walking/mobility, and management of medications and treatments. R3 had short-term and long-term memory and impaired decision-making cognitive difficulties and was sometimes understood and sometimes understood others during communication.

The 01/27/25 "NSA" identified the facility staff provided R3 physical assistance with bathing, dressing, and toileting and emptied indwelling urinary catheter bag. Staff provided full assistance of two staff for transfers and one staff assisted with mobility. Facility staff managed medications and treatments and provided verbal prompting and cueing as needed for cognitive difficulties. Facility staff provided one-step simple directions for R3 to follow and repeated information as needed. R3 had skin wound(s) on "areas of inner aspect of left buttock" managed by a hospice provider.

The 01/23/25 at 12:56 AM "Alert Charting Note" documented R3 returned from hospital that day with "some kind of hip procedure" completed. Surgery area was intact.

The 01/27/25 nursing "Alert Charting Note" documented R3's bilateral buttocks were reddened with two small superficial open areas on left inner buttocks. Orders received for skin prep to R3's bilateral heels due to increased risk of skin alteration due to decreased mobility.

The 01/28/25 "eMAR General Note" documented an order to apply wound treatment ointment to R3's buttocks and coccyx daily and every shift as

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needed.

Review of progress notes from 01/23/25 to 02/22/25 revealed lack of evidence of documentation licensed facility staff monitored R3's skin and implemented interventions to prevent pressure wounds and documented pressure wounds after they developed, including time of origin, wound sizes (length, width, and depth), odor, tissue characteristics (including drainage, granulation), any signs of infection, and plan for treatment.

- Record review for R6 revealed an admission date of 03/14/24 with a diagnosis of dementia.

The 09/21/24 "FCS" identified R6 required physical assistance with bathing, dressing, toileting, transfers, and eating. He was unable to perform walking/mobility and management of medications and treatments; he had short-term and long-term, memory recall, and decision-making cognitive difficulties; and he was marked at risk for falls.

The 04/18/24 (most recent) "NSA" identified the facility staff provided R6 physical assistance with bathing, dressing, toileting, and cut up his food in the kitchen for eating. Facility staff managed of medications and treatments and provided assistance of one staff with a gait belt to prevent injury from falls. The "NSA" failed to describe services provided for cognitive difficulties.

The 06/19/24 "Skin Observation Form (Quarterly)" documented R6 had intact skin with a Braden Score of "16 or less" which indicated "prevention strategies required."

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S3026	Continued From page 9 Review of R6's nursing progress notes from 03/14/24 to 10/25/24 revealed the following: The 09/24/24 "General Progress Note" Late Entry documented the nurse practitioner was notified that R6 had excoriation on both buttocks with right side "hard and red. The nurse received a new order for A&D Ointment applied daily. From 03/18/24 to 09/24/24 was 190 days R6's record lacked evidence of documentation of nursing progress notes including staff monitoring of R6's skin and interventions to prevent pressure wounds and documented pressure wounds after they developed, including time of origin, wound sizes (length, width, and depth), odor, tissue characteristics (including drainage, granulation), any signs of infection, and plan for treatment. The 09/26/24 at 06:08 PM "General Progress Note" documented the nurse practitioner was in the facility on 09/25/24 to assess R6's right buttocks. The nurse received a new order for Keflex (antibiotic medication). The 09/26/24 at 11:48 PM "Alert Charting Note" documented at 11:02 PM R6 was able to sit up and take medications with assistance. Diaphoresis (sweating) and general weakness with movements were noted. The 09/27/24 at 09:46 AM "Transfer Out to Hospital Note" documented R6 refused to get out of bed, was slow to answer and stated he didn't feel well. Facility staff notified the nurse practitioner and received orders to transport R6	S3026		

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to the hospital for evaluation due to daily decline and possible abscess on right buttock.

The 09/30/24 "General Progress Note" documented hospital staff reported R6 was "not well at all" due to Methicillin-resistant Staphylococcus aureus (MRSA) infection in bloodstream.

- Record review for R7 revealed an admission date of 02/12/24 with diagnoses of dementia and type two diabetes mellitus.

The 05/20/25 "FCS" revealed R7 required physical assistance with bathing, dressing and toileting, transfers, and walking/mobility. He was unable to perform management of medications and treatments. R7 was sometimes incontinent of bladder and had short-term and long-term memory and impaired decision-making cognitive difficulties. He was marked at risk for falls and impaired decision-making.

The 05/20/25 "NSA" identified the facility staff provided R7 physical assistance with bathing, dressing, and toileting. Staff provided full assistance and used gait belt for transfers and assisted with mobility. Facility staff managed medications and treatments and provided assistance with incontinence. Facility staff provided reminders and/or "physical attention" for cognitive difficulties and used a gait belt with transfers and ambulation or used a wheelchair to prevent injury from falls. R7 had a DPOA to assist with decision-making. The "NSA" identified licensed staff provided monitoring for signs of potential impaired skin integrity and provided "proactive attention to concerns to prevent

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breakdown." A home health provider provided wound care. All healthcare services were coordinated and supervised by Administrative Nurse C.

The 08/19/25 "Skin Observation Form (Quarterly)" documented R7 had intact skin with a Braden Score of "16 or less" which indicated "prevention strategies required."

Review of R7's nursing progress notes from 02/12/24 to 08/25/25 revealed the following:

The 02/14/24 "Alert Charting Note" documented R7 suffered a skin tear to his right arm. The nurse cleansed and bandaged the wound.

The 06/08/24 "eMAR General Note" documented R7 received a liquid protein supplement twice daily for wound healing.

From 02/14/24 to 06/08/24 (115 days) and from 06/08/24 to 06/24/24 (16 days) R7's record lacked evidence of documentation licensed facility staff monitored R7's skin and implemented interventions to prevent pressure wounds and documented pressure wounds after they developed, including time of origin, wound sizes (length, width, and depth), odor, tissue characteristics (including drainage, granulation), any signs of infection, and plan for treatment.

The 06/24/24 "eMAR General Note" documented home health licensed nurse cleansed bilateral lower extremities with wound cleanser, patted dry, applied zinc oxide to wound area and any areas of maceration, applied Xeroform to wound beds(s), wrapped with gauze, and secured with

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S3026	Continued From page 12 Kerlix. The 09/07/24 "Alert Charting Note" documented facility staff administered the initial dose of antibiotic treatment and performed wound care. From 06/24/24 to 09/07/24 (75 days) R7's record lacked evidence of documentation licensed facility staff monitored R7's skin and implemented interventions to prevent pressure wounds and documented pressure wounds after they developed, including time of origin, wound sizes (length, width, and depth), odor, tissue characteristics (including drainage, granulation), any signs of infection, and plan for treatment. The 02/28/25 "Return from Hospital Note" documented R7 arrived back to the community. A nurse completed an assessment with no abnormalities noted. Bruises were present on both hands. The 03/02/25 at 08:45 AM "Alert Charting Note" documented R7 had a 5.0-centimeter (cm) x 4.0 cm blister with black/purple colored pressure type wound on his left heel and a 0.9 cm x 0.5 cm open wound on the tip of his left great toe. The 03/03/25 "Alert Charting Note" documented the nurse practitioner examined his pressure ulcer and a nurse cleaned and dressed it. The 03/07/25 "Alert Charting Note" documented a home health nurse completed wound care for R7. His wound measured 3.0 x 5.0 cm with bruising around his heel. The 04/16/25 skin observation sheet by CNA K	S3026		

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reported skin was "very red" and "painful to touch" with a hand drawn circle around the coccyx area.

The 05/16/25 "Transfer Out to Hospital Note" documented the home health nurse observed R7 responded to his name but would not open his eyes or squeeze the nurse's hands. He had a temperature of 100.3 degrees Fahrenheit (F), heart rate 99 beats per minute (bpm), blood pressure of 190/93 mmHg, and an oxygen saturation rate of 93%.

From 03/07/25 to 05/16/25 (70 days) lacked evidence of documentation licensed facility staff monitored R7's skin (including when direct-care staff reported skin issues on 04/16/25) and implemented interventions to prevent pressure wounds and documented pressure wounds after they developed, including time of origin, wound sizes (length, width, and depth), odor, tissue characteristics (including drainage, granulation), any signs of infection, and plan for treatment.

The 05/19/25 "General Progress Note" documented a hospital nurse reported to facility staff R7 had increased lactic acid and white blood cell levels at the time he admitted to the hospital.

The 05/20/25 "Return from Hospital Note" documented R7 returned to the facility on antibiotic treatment. Pressure ulcer on his left heel had 50% slough with no drainage or odor.

The 05/21/25 "Alert Charting Note" documented a home health nurse dressed R7's heel wounds and had no concerns.

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BROOKDALE SHAWNEE	11400 W 65TH STREET SHAWNEE, KS 66203

(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
S3026	Continued From page 14 The 06/04/25 skin observation sheet by CNA K reported "dry spots" with a hand drawn circle around the right gluteal cleft and "bleeding on testicle." - Record review for R9 revealed an admission date of 02/21/25 with diagnoses of hemiplegia and hemiparesis following cerebral infarction of right dominant side and type two diabetes mellitus. The 02/21/25 "FCS" revealed R9 required physical assistance with bathing, dressing and toileting, transfers, and walking/mobility. She was unable to perform management of medications and treatments. R9 was frequently incontinent of bladder and had short-term and long-term memory and impaired decision-making cognitive difficulties. She was marked at risk for falls and impaired decision-making. The 03/25/25 "NSA" identified the facility staff provided R9 physical assistance with bathing, dressing, and toileting. Staff provided full assistance for transfers and she propelled herself in a wheelchair for mobility. Facility staff managed medications and treatments and provided assistance with incontinence. Facility staff provided prompts during daily routines for cognitive difficulties and provided assistance with transfers to prevent injury from falls. R9 had a DPOA to assist with decision-making. The 05/21/25 "Skin Observation Form (Quarterly)" documented R9 had intact skin with a Braden Score of "16 or less" which indicated "prevention strategies required."	S3026		

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S3026	Continued From page 15 The 07/17/25 skin observation sheet by an unidentified CNA reported a "knot under the skin" that was open with a hand drawn circle on the right buttock. Review of R9's nursing progress notes from 02/21/25 at admission to 07/18/25 revealed the following: The 07/18/25 "Transfer Out to Hospital Note" documented R9 had an abscess to her left buttock that was red and warm to touch. R9's was flushed and warm but did not have a fever. R9 went to the hospital for observation. From 02/21/25 at admission to 07/18/25 (when she transferred to the hospital for an abscess) R9's lacked evidence of documentation licensed facility staff monitored skin. On 08/28/25 at approximately 12:31 PM Administrative Nurse C confirmed the nursing progress notes for R1, R3, R6, R7, and R9 lacked evidence of documentation facility staff monitored their skin and implemented interventions to prevent pressure wounds and documented pressure wounds after they developed, including time of origin, wound sizes (length, width, and depth), odor, tissue characteristics (including drainage, granulation), any signs of infection, and plan for treatment. The revised on 08/2024 facility's "Documentation Policy" recorded documentation was completed by exceptions which included resident refusal, change in condition, unexpected clinical outcomes, physician/healthcare provider and	S3026		

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S3026	Continued From page 16 responsible party notification or other conditions and may be documented in detail in the residents' electronic record "Progress Notes." The administrator failed to protect five residents from neglect which resulted in harm by the failure to ensure facility licensed staff provided timely nursing skin assessments, documentation of skin wounds, and coordinated plans of care for R1, R3, R6, R7, and R9.	S3026		
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. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1)(2)	S3085		

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S3085	Continued From page 17 The facility reported a census of 30 residents with three residents included in the sample and eight focused reviews. Based on observation, interview, and record review the administrator failed to ensure the "Negotiated Service Agreements" (NSAs) for Residents (R) 1, R4, R5, R6, R7, R10 and R11 described the services they received and the provider of services on their "Functional Capacity Screens" (FCSs). Findings included: - Record review for R1 revealed an admission date of 03/01/25 with diagnoses of Alzheimer's Disease and degenerative disease of nervous system. The 04/28/25 "FCS" identified R1 required physical assistance with eating. The 04/28/25 "NSA" failed to describe services provided for eating, skin and/or wound care, daily catheter care and failed to list the providers of the services and failed to name a third party outside party for hospice services. - Record review for R4 revealed an admission date of 04/16/24 with diagnoses of dementia and repeated falls. The 04/16/24 "FCS" identified R4 was at risk for wandering. The 06/18/24 "NSA" failed to describe services provided for wandering behavior. The 06/12/24 "Intake Information" form to the	S3085		

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S3085	Continued From page 18	S3085		

department reported on 06/11/24 a staff member found R4 walking outside the facility without staff knowledge she exited the building.

- Record review for R5 revealed an admission date 06/29/23 with diagnoses of dementia, cerebral infarction, and repeated falls.

The 04/22/25 "FCS" identified R5 required physical assistance with grooming tasks.

The 04/22/25 "NSA" failed to name the provider for grooming services R5 received.

Observation on 08/25/25 at 01:25 PM revealed R5 self propelled his wheelchair in the common area. He had food crumbs on his clothing, food remains around his mouth and down his chin, facial hair appeared to have several days of growth, and his fingernails appeared long and dirty.

Observation on 08/26/25 at 10:53 AM revealed R5 appeared clean and freshly shaven with fingernails long and dirty.

Observation 08/28/25 at 09:55 AM revealed R5 appeared neat and clean but his fingernails were still long and dirty.
On 08/27/25 at approximately 01:04 PM Certified Nurse Aide (CNA) K stated R4 required physical assistance with grooming and received a shave as needed. The "activity people" were responsible for providing nail care which was done once a week.

On 08/27/25 at approximately 02:22 PM Certified Medication Aide (CMA) M stated the CNA's were

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S3085	Continued From page 19	S3085		

responsible for providing shaving and clipping and cleaning fingernails.

On 08/27/25 at 03:34 PM Administrative Staff B confirmed R5's were too long.

- Record review for R6 revealed an admission date of 03/14/24 with a diagnosis of dementia.

The 09/21/24 "FCS" identified R6 had short-term and long-term, memory recall, and decision-making cognitive difficulties.

The 04/18/24 (most recent) "NSA" failed to describe services provided for cognitive difficulties.

- Record review for R7 revealed an admission date of 02/12/24 with diagnoses of dementia and type two diabetes mellitus.

The 05/20/25 "FCS" identified R7 had short-term and long-term memory and impaired decision-making cognitive difficulties.

The 05/20/25 "NSA" failed to describe services provided for cognitive difficulties.

- Record review for R10 revealed an admission date of 12/05/24 with a diagnosis of dementia.

The 07/21/25 "FCS" identified R10 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties.

The 01/10/25 (most recent) "NSA" failed to describe the services R10 received for cognitive

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S3085	Continued From page 20 difficulties. - Record review for R11 revealed an admission date of 08/06/25 with a diagnosis of dementia. The 08/06/25 "FCS" identified R11 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. The 08/06/25 "NSA" failed to describe the services R11 received for cognitive difficulties. On 08/28/25 at approximately 12:31 PM Administrative Nurse C confirmed R1, R4, R5, R6, R7, R10 and R11's NSAs failed to describe the services they received and the provider of the services. She stated the residents' "Service Plans" were also the "NSAs." The revised 03/2020 "Service Plan Policy" documented resident service plans provided information about residents' needs to the care associates. The administrator failed to ensure the "NSAs" for R1, R4, R5, R6, R7, R10 and R11 described the services they received and the provider of services on their "FCSs."	S3085		
S3101 SS=D	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal	S3101		

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S3101	Continued From page 21 representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 30 residents. The sample included three residents and eight abbreviated record reviews. Based on interview and record review the administrator failed to ensure everyone involved in the development of the "Negotiated Service Agreement" (NSA) for R3 signed the contract. Findings included: - Record review for R3 revealed an admission date of 07/15/21 with a diagnosis of dementia. The 01/27/25 "FCS" revealed R3 required physical assistance with bathing, dressing and toileting. He was unable to perform transfers, walking/mobility, and management of medications and treatments. R3 had short-term and long-term memory and impaired decision-making cognitive difficulties and was sometimes understood and sometimes understood others during communication. The 01/27/25 "NSA" identified the facility staff provided R3 physical assistance with bathing, dressing, and toileting and emptied indwelling urinary catheter bag. Staff provided full assistance of two staff for transfers and one staff assisted with mobility. Facility staff managed	S3101		

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S3101	Continued From page 22 medications and treatments and provided verbal prompting and cueing as needed for cognitive difficulties. Facility staff provided one-step simple directions for R3 to follow and repeated information as needed. R3 had skin wound(s) on "areas of inner aspect of left buttock" managed by a hospice provider. The 01/27/25 "NSA" for R3 lacked signatures of designated facility staff resident/legal representatives. In an interview on 08/28/25 at approximately 10:50 AM Administrative Nurse C confirmed the "NSA" for R3 lacked signatures of designated facility staff and R3's resident/legal representative. The revised 03/2020 facility's "Service Plan Process Policy - CS -70 -3" documented that upon initial review and subsequent changes, members of the community care team that contributed to the service plan, including the ED or designee, or nurse and the resident/legally responsible party should sign the service plan. The administrator failed to ensure designated staff and resident/legal representative involved in the development of the "NSA" for R3 was signed as stated in facility policy "Service Plan Process Policy-CS-70-3".	S3101		

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S3101	Continued From page 23	S3101		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 30 residents with 3 included in the sample and eight focused reviewed. Based on observation, interview, and record review the administrator failed to ensure a licensed nurse coordinated care to meet Resident (R) 1, R3, R5, R7, and R10's, needs in accordance with their "Functional Capacity Screens" (FCSs) and "Negotiated Service Agreements" (NSAs). Findings included: - Review of R1's record revealed an admission date of 03/01/25 with diagnoses of Alzheimer's	S3155		

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S3155	Continued From page 24 Disease and degenerative disease of nervous system. The 04/28/25 "FCS" identified R1 required physical assistance with bathing, dressing, and toileting and was frequently incontinent of bladder. R1 had short term, long term, memory recall and impaired decision-making cognitive difficulties. The 04/28/25 "NSA" identified facility staff provided R1 physical assistance with bathing, dressing, and toileting. R1 had fragile, thin skin with a small open area on the back of her right lower leg on 04/04/25. The NSA failed to describe services provided for skin and/or wound care, daily catheter care and failed to list the providers of the services. The 08/26/25 (during the survey) "NSA" identified facility staff provided check and change for incontinence care and repositioning. Observation on 08/28/25 at 09:12 AM revealed two staff changed R1 in bed. Her buttocks and coccyx wound appeared to have deep red tissue in a large circular area with several open areas scattered throughout the wound bed. Staff applied zinc oxide to wound area per direction of Administrative Nurse C. Staff assisted R1 onto her right side with a pillow between her knees, a pillow behind her back, and offloading boots on both feet. R1 remained unresponsive throughout the process. Staff completed cares and exited R1's room at 09:12 AM. Observation of R1 continued from 09:12 AM through 11:22 AM (two hours and ten minutes)	S3155		

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S3155	Continued From page 25	S3155		

revealed no staff returned to provide services listed on NSA as follows: checked and change if needed and/or repositioned.

On 08/28/25 at 11:25 AM Administrative Nurse C stated facility staff should be checking on R1 at least every two hours and "do what they need to do."

On 08/28/25 at approximately 12:31 PM Administrative Nurse J confirmed R1's "NSA" did not specify timing of how often staff performed check and change and repositioned her but expected them provide services at least every two hours.

- Record review for R3 revealed an admission date of 07/15/21 with a diagnosis of dementia.

The 01/27/25 "FCS" revealed R3 required physical assistance with bathing and was unable to perform transfers.

The 01/27/25 "NSA" identified the facility staff provided R3 physical assistance with bathing and full assistance of two staff for transfers.

The 07/27/25 "Alert Charting Note" documented R3 fell on the shower floor at 07:00 PM with one staff member present. Certified Nurse Aide (CNA) D reported she was not strong enough to hold R3 when he held onto the bars and stood up in the shower.

- Record review for R5 revealed an admission date 06/29/23 with diagnoses of dementia, cerebral infarction, and repeated falls.

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S3155	Continued From page 26 The 04/22/25 "FCS" identified R5 required physical assistance with grooming tasks. The 04/22/25 "NSA" failed to name the provider for grooming services R5 received. Observation on 08/25/25 at 01:25 PM revealed R5 self propelled his wheelchair in the common area. He had food crumbs on his clothing, food remains around his mouth and down his chin, facial hair appeared to have several days of growth, and his fingernails appeared long and dirty. Observation on 08/26/25 at 10:53 AM revealed R5 appeared clean and freshly shaven with fingernails long and dirty. Observation 08/28/25 at 09:55 AM revealed R5 appeared neat and clean but his fingernails were still long and dirty. On 08/27/25 at approximately 01:04 PM Certified Nurse Aide (CNA) K stated R4 required physical assistance with grooming and received a shave as needed. The "activity people" were responsible for providing nail care which was done once a week. On 08/27/25 at approximately 02:22 PM Certified Medication Aide (CMA) M stated the CNA's were responsible for providing shaving and clipping and cleaning fingernails. On 08/27/25 at 03:34 PM Administrative Staff B confirmed R5's were too long. - Record review for R7 revealed an admission date of 02/12/24 with diagnoses of dementia and	S3155		

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S3155	Continued From page 27	S3155		

type two diabetes mellitus.

The 05/20/25 "FCS" revealed R7 required physical assistance with toileting and was sometimes incontinent of bladder.

The 05/20/25 "NSA" identified licensed staff provided monitoring for signs of potential impaired skin integrity and provided "proactive attention to concerns to prevent breakdown."

Review of R7's record lacked evidence of documentation licensed facility staff monitored R7's skin (including when direct-care staff reported skin issues on 04/16/25) and implemented interventions to prevent pressure wounds and documented pressure wounds after they developed.

- Record review for R10 revealed an admission date of 12/05/24 with a diagnosis of dementia.

The 07/21/25 "FCS" identified R10 was at risk for wandering.

The 01/10/25 (most recent) "NSA" identified R10 required redirection for wandering.

The 08/22/25 "Alert Charting Note" documented direct-care staff reported they found R10 lying with a male resident in his bed. Staff escorted R10 out of the male resident's room without difficulty, without injuries, and she denied pain or discomfort. Staff placed R10 on alert charting and monitoring for 72 hours.

The 08/25/25 "Alert Charting Note" documented R10 was on alert charting for incidents that

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S3155	Continued From page 28 occurred on 08/22/25 and another one on 08/23/25. R10's record lacked evidence of documentation staff provided redirection when she wandered into a male resident's room on 08/22/25 and 08/23/25. The revised 03/2020 "Service Plan Policy" documented resident service plans provided information about residents' needs to the care associates. The plans would identify individual residents' needs and approaches to meet these needs. The administrator failed to ensure a licensed nurse coordinated care to meet R1, R3, R5, R7, and R10's, needs in accordance with their "FCSs" and "NSAs".	S3155		
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 30 residents with three residents included in the sample and eight focused reviews. Based on observation,	S3261		

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S3261	Continued From page 29 interview, and record review the administrator failed to ensure licensed staff documented all incidents, symptoms, indications of illness or injury including the dates, times, actions taken, and results of the actions for Residents (R) 1, R2, R3, R6, R7, R9, and R10. Findings included: - Review of R1's record revealed an admission date of 03/01/25 with diagnoses of Alzheimer's Disease and degenerative disease of nervous system. The 04/28/25 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with bathing, dressing, toileting and eating. She was unable to perform transfers and management of medications and treatments. R1 was frequently incontinent of bladder and had short term, long term, memory recall and impaired decision-making cognitive difficulties. The 04/28/25 "Negotiated Service Agreement" (NSA) identified facility staff provided R1 physical assistance with bathing, dressing, and toileting. Two staff provided assistance and used a mechanical lift for transfers. Facility staff provided physical assistance with walking/mobility and managed medications and treatments. She had difficulty during communication with finding words and finishing thoughts. Staff provided prompts and cues as needed. R1 had fragile, thin skin and staff encouraged her to communicate with medical staff as needed if she had any skin concerns. She had a small open area on the back of her	S3261		

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right lower leg on 04/04/25. The NSA failed to describe services provided for eating, falls, skin and/or wound care, daily catheter care and the providers of the services.

Review of R1's nursing progress notes from 04/04/25 to 08/25/25 revealed the following:

The 04/21/25 "Alert Charting Note" documented R1's family expressed concerns about her declining status. The facility nurse notified the nurse practitioner and received orders for antibiotic therapy. The note lacked evidence of documentation that described how R1's status had declined, including any incidents, symptoms, and other indications of illness of injury with date, time of occurrence, actions taken, and results of the actions.

The 04/22/25 "Transfer Out to Hospital Note" documented R1 had a decline in level of consciousness with large painful abdomen, and faint bowel sounds. Paramedics arrived on site, placed an intravenous line, obtained vital signs, and administered oxygen via nasal cannula for shortness of air. The note lacked evidence of documentation of date and time of onset of symptoms, any other indications of illness or injury including the date, time of occurrence, actions taken, and results of the actions.

The 04/28/25 "Return from Hospital Note" documented R1 returned from the hospital with an indwelling urinary catheter for a urinary tract infection. A small, reddened area was on the left side of her coccyx, and she required assistance with a mechanical lift to transfer to bed. The note lacked evidence of documentation of size and

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S3261	Continued From page 31 characteristics of red area on left side of coccyx. The 05/08/25 "Care Conference Note" documented a meeting occurred between R1's Durable Power of Attorney (DPOA) and Administrative Nurse C where they discussed R1's hospital visit, a blister on her heel, and redness on her left knee. The note lacked evidence of documentation of the location of the blister (right or left heel) and blister characteristics, including signs of infection, and size and characteristics of redness on R1's left knee and actions taken and results of the action. The 05/09/25 skin observation sheet by Certified Nurse Aid (CNA) D documented a "sore" with a hand drawn circle around approximately the coccyx. Review of nursing progress notes from 05/09/25 (when direct-care staff informed the licensed nurse R1 had a sore in her coccyx area) lacked evidence of documentation of a coccyx wound incidents, symptoms, or other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. The 06/13/25 "General Note From eMar" and the 07/22/25 "Physician's Order Note" documented R1 received eye medication for seven days for both occurrences for conjunctivitis. R1's record lacked evidence of documentation of any eye incidents, symptoms, or other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.	S3261		

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S3261	Continued From page 32 Review of skin observation sheets from 06/24/25 to 08/22/25 revealed unidentified facility and/or hospice staff reported skin issues seven times on 06/24/25, 07/01/25, 07/08/25, 07/15/25, 07/18/25, 07/22/25, and 08/22/25. Review of nursing progress notes from 06/24/25 to 08/22/25 lacked evidence of follow up documentation when direct-care staff observed and reported skin issues. The 08/05/25 hospice "Skilled Nursing Visit" note documented R1 had multiple poorly healing wounds to bilateral heels and coccyx and received treatment for bilateral eye infection with an ophthalmic antibiotic. The 08/07/25 hospice "Skilled Nursing Visit" note documented one of R1's eyes was matted shut and the hospice nurse cleansed it with a warm rag and soap water until the crust cleared and R1's eye opened. The hospice nurse also provided wound care at that time. The 08/08/25 hospice "Skilled Nursing Visit" note documented R1had one eye open and the other crusted shut. The hospice nurse washed R1's eye with a warm compress until the eye "eventually uncrusted and opened." The 08/19/25 hospice "Skilled Nursing Visit" note documented a sore on R1's bottom worsened. Hospice nurse educated facility staff of the need to offload R1 out of her reclining wheelchair and onto her side in bed often. The hospice nurse also updated and educated Administrative Nurse C who confirmed understanding.	S3261		

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S3261	Continued From page 33 Observation on 08/28/25 at 09:12 AM revealed two staff changed R1 in bed. Her buttocks including coccyx wound appeared to have deep red tissue in a large circular area with several open areas scattered throughout the wound bed. Staff applied zinc oxide to wound area per direction of Administrative Nurse C. Staff assisted R1 onto her right side with a pillow between her knees, a pillow behind her back, and offloading boots on both feet. R1 remained unresponsive throughout the process. Staff completed cares and exited R1's room at 09:12 AM. - Record review for R2 revealed an admission date of 01/04/23 with diagnoses of dementia, repeated falls, and Parkinson's Disease. The 08/02/23 (most recent) "FCS" identified R2 required physical assistance with bathing, dressing, and toileting; was unable to perform management of medications and treatments, was occasionally incontinent of bladder; had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties; and was marked at risk for falls and impaired decision-making. The 02/18/25 "NSA" identified facility staff provided R2 physical assistance with bathing, dressing, and toileting; management of medications and treatments; assistance with perineal hygiene for bladder incontinence; prompting and cueing for cognitive difficulties; reminders to use call pendant, reminders to wear a soft helmet, encouragement to wear gripper socks, kept familiar items within reach, and reminders to use walker to prevent injury from	S3261		

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falls. She had DPOA to assist with decisions.

The 08/25/25 "Resident Roster" revealed R2 no longer lived in facility.

The 04/12/24 nursing "General Progress Note" documented a nurse from an area hospital stated R2 may be discharged that same day but if not, for sure on Saturday. Review of nursing progress notes before and after 04/12/24 from 04/10/25 to 04/13/24 lacked evidence of documentation of any incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action when R2 transferred to the hospital. Her record also lacked evidence of documentation when she returned back to the facility.

The 05/02/25 (final entry) "Weight Change Note" documented R2's weight was stable.

Review of nursing progress notes for R2 lacked evidence of documentation R2 discharged from the facility and all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action from 05/02/25 until discharge.

- Record review for R3 revealed an admission date of 07/15/21 with a diagnosis of dementia.

The 01/27/25 "FCS" revealed R3 required physical assistance with bathing, dressing and toileting. He was unable to perform transfers, walking/mobility, and management of medications and treatments. R3 had short-term and long-term memory and impaired decision-making cognitive difficulties and was

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sometimes understood and sometimes understood others during communication.

The 01/27/25 "NSA" identified the facility staff provided R3 physical assistance with bathing, dressing, and toileting and emptied indwelling urinary catheter bag. Staff provided full assistance of two staff for transfers and one staff assisted with mobility. Facility staff managed medications and treatments and provided verbal prompting and cueing as needed for cognitive difficulties. Facility staff provided one-step simple directions for R3 to follow and repeated information as needed. R3 had skin wound(s) on "areas of inner aspect of left buttock" managed by a hospice provider.

On 09/02/25 at 04:20 PM skin assessments for R3 were requested in an email which the facility failed to provide.

The 01/23/25 at 12:56 AM "Alert Charting Note" documented R3 returned from hospital that day with "some kind of hip procedure" completed. Surgery area was intact.

The 01/27/25 nursing "Alert Charting Note" documented R3's bilateral buttocks were reddened with two small superficial open areas on left inner buttocks. Orders received for skin prep to R3's bilateral heels due to increased risk of skin alteration due to decreased mobility.

The 01/28/25 "eMAR General Note" documented an order to apply wound treatment ointment to R3's buttocks and coccyx daily and every shift as needed.

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S3261	Continued From page 36 Review of progress notes from 01/23/25 to 02/22/25 lacked evidence of documentation of all indications of illness or injury including the date, time of occurrence, action taken, and results of the action when R3 developed reddened areas on his buttocks. - Record review for R6 revealed an admission date of 03/14/24 with a diagnosis of dementia. The 09/21/24 "FCS" identified R6 required physical assistance with bathing, dressing, toileting, transfers, and eating. He was unable to perform walking/mobility and management of medications and treatments; he had short-term and long-term, memory recall, and decision-making cognitive difficulties; and he was marked at risk for falls. The 04/18/24 (most recent) "NSA" identified the facility staff provided R6 physical assistance with bathing, dressing, toileting, and cut up his food in the kitchen for eating. Facility staff managed of medications and treatments and provided assistance of one staff with a gait belt to prevent injury from falls. The "NSA" failed to describe services provided for cognitive difficulties. Review of R6's nursing progress notes from 03/14/24 to 10/25/24 revealed the following: The 03/15/24 "Alert Charting Note" documented R6 was on alert charting for new admission on 03/14/24. The 03/18/24 "Alert Charting Note" documented 72 hours of alert charting for new admission were completed and would continue with plan of care.	S3261		

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S3261	Continued From page 37 The 09/24/24 "General Progress Note" Late Entry documented the nurse practitioner was notified that R6 had excoriation on both buttocks with right side "hard and red. The nurse received a new order for A&D Ointment applied daily. From 03/18/24 to 09/24/24 was 190 days R6's record lacked evidence of documentation of all incidents, symptoms, and other indications or injury including the date, time of occurrence, action taken, and results of the action. The 09/26/24 at 06:08 PM "General Progress Note" documented the nurse practitioner was in the facility on 09/25/24 to assess R6's right buttock. The nurse received a new order for Keflex (antibiotic medication). The 09/26/24 at 11:48 PM "Alert Charting Note" documented at 11:02 PM R6 was able to sit up and take medications with assistance. Diaphoresis (sweating) and general weakness with movements were noted. The 09/27/24 at 09:46 AM "Transfer Out to Hospital Note" documented R6 refused to get out of bed, was slow to answer and stated he didn't feel well. Facility staff notified the nurse practitioner and received orders to transport R6 to the hospital for evaluation due to daily decline and possible abscess on right buttock. The 09/30/24 "General Progress Note" documented hospital staff reported R6 was "not well at all" due to Methicillin-resistant Staphylococcus aureus (MRSA) infection in bloodstream.	S3261		

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S3261	Continued From page 38 - Record review for R7 revealed an admission date of 02/12/24 with diagnoses of dementia and type two diabetes mellitus. The 05/20/25 "FCS" revealed R7 required physical assistance with bathing, dressing and toileting, transfers, and walking/mobility. He was unable to perform management of medications and treatments. R7 was sometimes incontinent of bladder and had short-term and long-term memory and impaired decision-making cognitive difficulties. He was marked at risk for falls and impaired decision-making. The 05/20/25 "NSA" identified the facility staff provided R7 physical assistance with bathing, dressing, and toileting. Staff provided full assistance and used gait belt for transfers and assisted with mobility. Facility staff managed medications and treatments and provided assistance with incontinence. Facility staff provided reminders and/or "physical attention" for cognitive difficulties and used a gait belt with transfers and ambulation or used a wheelchair to prevent injury from falls. R7 had a DPOA to assist with decision-making. The "NSA" identified licensed staff provided monitoring for signs of potential impaired skin integrity and provided "proactive attention to concerns to prevent breakdown." A home health provider provided wound care. All healthcare services were coordinated and supervised by Administrative Nurse C. The 04/16/25 skin observation sheet by CNA K reported skin was "very red" and "painful to touch" with a hand drawn circle around	S3261		

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S3261	Continued From page 39 approximately the coccyx. The 06/04/25 skin observation sheet by CNA K reported "dry spots" with a hand drawn circle around approximately the right gluteal cleft and "bleeding on testicle." Review of R7's nursing progress notes from 04/16/24 to 08/25/25 revealed the following: The 05/16/25 "Transfer Out to Hospital Note" documented the home health nurse observed R7 responded to his name but would not open his eyes or squeeze the nurse's hands. He had a temperature of 100.3 degrees Fahrenheit (F), heart rate 99 beats per minute (bpm), blood pressure of 190/93 mmHg, and an oxygen saturation rate of 93%. From 04/16/25 to 05/16/25 (30 days) lacked evidence of documentation of all indications of illness or injury including the date, time of occurrence, action taken, and results of the action when direct-care staff reported R7 had a skin issue. The 05/19/25 "General Progress Note" documented a hospital nurse reported to facility staff R7 had increased lactic acid and white blood cell levels at the time he admitted to the hospital. From 06/04/25 to 08/25/25 (82 days) lacked evidence of documentation all indications of illness or injury including the date, time of occurrence, action taken, and results of the action when direct-care staff reported R7 had a skin issue.	S3261		

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S3261	Continued From page 40 - Record review for R9 revealed an admission date of 02/21/25 with diagnoses of hemiplegia and hemiparesis following cerebral infarction of right dominant side and type two diabetes mellitus. The 02/21/25 "FCS" revealed R9 required physical assistance with bathing, dressing and toileting, transfers, and walking/mobility. She was unable to perform management of medications and treatments. R9 was frequently incontinent of bladder and had short-term and long-term memory and impaired decision-making cognitive difficulties. She was marked at risk for falls and impaired decision-making. The 03/25/25 "NSA" identified the facility staff provided R9 physical assistance with bathing, dressing, and toileting. Staff provided full assistance with transfers and she propelled herself in a wheelchair for mobility. Facility staff managed medications and treatments and provided assistance with incontinence. Facility staff provided prompts during daily routines for cognitive difficulties and provided assistance with transfers to prevent injury from falls. R9 had a DPOA to assist with decision-making. The 07/17/25 skin observation sheet by an unidentified CNA reported a "knot under the skin" that was open with a hand drawn circle on the right buttock. Review of R9's nursing progress notes from 02/21/25 at admission to 07/18/25 revealed the following:	S3261		

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S3261	Continued From page 41 The 07/18/25 "Transfer Out to Hospital Note" documented R9 had an abscess to her left buttock that was red and warm to touch. R9's was flushed and warm but did not have a fever. R9 went to the hospital for observation. From 02/21/25 at admission to 07/18/25 (when she transferred to the hospital for an abscess) R9's record lacked evidence of documentation all indications of illness or injury including the date, time of occurrence, action taken, and results of the action when direct-care staff reported R7 had a skin issue. - Record review for R10 revealed an admission date of 12/05/24 with a diagnosis of dementia. The 07/21/25 "FCS" identified R10 required physical assistance with bathing, dressing, and toileting. She was unable to perform management of medications and treatments and was frequently incontinent of bladder. R10 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties and was marked at risk for impaired decision-making and wandering. The 01/10/25 (most recent) "NSA" identified facility staff provided R10 stand-by and physical assistance with bathing, cueing with potential assistance for dressing, and physical assistance with toileting. Facility staff managed medications and treatments and assisted with bladder incontinence. R10 had a DPOA to assist with decision-making and staff redirected her when wandered. The "NSA" failed to describe services provided cognitive difficulties.	S3261		

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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
S3261	Continued From page 42 The 08/22/25 "Alert Charting Note" documented direct-care staff reported they found R10 lying with a male resident in his bed. Staff escorted R10 out of the male resident's room without difficulty, without injuries, and she denied pain or discomfort. Staff placed R10 on alert charting and monitoring for 72 hours. The 08/25/25 "Alert Charting Note" documented R10 was on alert charting for incidents that occurred on 08/22/25 and another one on 08/23/25. R10's record lacked evidence of documentation of an incident between 08/22/25 and 08/25/25. Her record also lacked evidence of documentation of monitoring for 72 hours. On 08/28/25 at approximately 12:31 PM Administrative Nurse C confirmed resident records for R1, R2, R3, R6, R7, R9, and R10 lacked documentation of all incidents, symptoms, and other indications of illness or injury including date, time of occurrence, actions taken, and results of the actions. The revised on 08/2024 facility's "Documentation Policy" documented documentation was completed by exceptions which included resident refusal, change in condition, unexpected clinical outcomes, physician/healthcare provider and responsible party notification or other conditions and may be documented in detail in the residents' electronic record "Progress Notes." The administrator failed to ensure licensed facility staff documented all incidents, symptoms, and other indications of illness or injury including	S3261		

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S3261	Continued From page 43 date, time of occurrence, actions taken, and results of the actions for R1, R2, R3, R6, R7, R9, and R10.	S3261		
S3305 SS=D	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (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 (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the	S3305		

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S3305	Continued From page 44 health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-207(a) The facility reported a census of 30 residents. The sample included three residents and eight abbreviated record reviews. Based on observation, interview, and record review, the administrator failed to ensure designated staff implemented hand hygiene procedures to prevent the spread of infection while changing incontinence briefs for Resident (R)1 and emptying her indwelling urinary catheter bag. Findings included: - (R)1 moved into the facility on 03/01/25 with a diagnosis of Alzheimer's Disease. The 04/28/25 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with bathing, dressing, toileting and eating. She was unable to perform transfers and management of medications and treatments. R1 was frequently incontinent of bladder, was sometimes understandable and usually understood others during communication; and she had short term, long term, memory recall and impaired decision-making cognitive difficulties. The 04/28/25 "Negotiated Service Agreement" (NSA) identified facility staff provided R1	S3305		

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S3305	Continued From page 45	S3305		

physical assistance with bathing, dressing, and toileting. Two staff provided assistance and used a mechanical lift for transfers. Facility staff provided physical assistance with walking/mobility and managed medications and treatments. She had difficulty during communication with finding words and finishing thoughts. Staff provided prompts and cues as needed. R1 had fragile, thin skin and staff encouraged her to communicate with medical staff as needed if she had any skin concerns. She had a small open area on the back of her right lower leg on 04/04/25.
The NSA failed to describe services provided for eating, falls, skin and/or wound care, daily catheter care and the providers of the services.

Observation on 08/28/25 at 09:12 AM revealed Certified Nurse Aide (CNA) K and CNA L provided incontinent care to R1. CNA K applied ointment to R1's buttocks, brief was secured, and blankets applied. CNA K and CNA L then placed R1 on her right side securing her position in bed with a pillow behind her back. CNA L entered the bathroom and retrieved a urinal for CNA K to drain R1's urinary catheter bag into. Observation revealed that the urinal had dark yellow stained urine on the rim. CNA K then placed the stained urinal directly on the floor and opened the outflow drainage port of the catheter bag to drain urine into urinal. Observation revealed that the outflow drainage port of the urinary catheter drainage bag continually hit the rim of the urinal. CNA K completed draining urinary catheter bag into stained urinal and placed the outflow drainage port directly into the urinary catheter bag. CNA L gave CNA K a clear plastic bag. CNA K placed the catheter drainage bag into the

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clear plastic bag and hung the clear plastic bag on the frame of the bed. CNA K and CNA L bagged the soiled linen and incontinence items and exited R1's room without performing hand hygiene.

Interview on 08/28/25 at approximately 09:18 AM, CNA K stated that he only cleaned the outflow drainage port of the urinary catheter "once in a while". CNA K stated "the wound care guy usually does catheter care, and he comes in a couple times a week". CNA K was unable to locate cleansing wipes for outflow drainage port in R1's room upon request of surveyor.

Interview on 08/28/25 at approximately 09:20 AM with CNA L stated that they were unaware if there was a scheduled change out for urinal and cylinders that were used for emptying urinary catheters. CNA L stated "I change them when I work". CNA L stated that she worked "a couple times a week".

Interview on 08/28/25 at 11:32 AM with Administrative Nurse C stated she expectated staff to cleanse the tip of the outflow drainage port of catheter bag at least once a shift.

Interview on 08/28/28 at 11:32 AM with Administrative Staff A and Administrative Staff B during the interview corrected Administrative Nurse C stated "you mean each time they dump the catheter".

The revised 06/2020 facility's policy "How to: Indwelling Catheter Care - 13" failed to identify infection prevention strategies for catheter care.

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S3305	Continued From page 47 The revised 05/2025 facility's policy "PLI7-001 Infection Control Plan" documented that the following tasks involved potential exposure to blood, body fluids, or potentially infectious material or disease: output measuring, specimen collecting, urine, cleaning body fluids and/or splashes. The policy further documented that the following procedures may involve potential exposure to infectious material and may be classified as Category 1 in some circumstances: assisting resident to and from bathroom, dressing/undressing resident, extended close proximity to a client, disposal of trash. Policy further states, Handwashing: All associates should practice hand washing using the following guidelines. Wash their hands immediately or as soon as practicable after the removal of gloves and/or other personal protective equipment. Hands or other areas of skin should be washed immediately following contact with contaminated or other potentially infectious materials. Associates should follow the hand washing protocols found in the training manual for effective results, using gloves is not a substitute for hand washing. An associate should wash his/her hands after the removal of gloves. Hand washing should be done immediately after removal of gloves/personal protective equipment. The administrator failed to ensure designated staff maintained a safe and sanitary environment for the residents to prevent the spread of infection when staff failed to use proper hand hygiene procedures to prevent the spread of infection when changing incontinence briefs for R1 and emptying her indwelling urinary catheter bag and failed to ensure designated staff provided safe, sanitary practices to keep R1 safe	S3305		

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S3305	Continued From page 48 from the spread of infections emptying her indwelling urinary catheter bag. The administrator further failed to ensure facility's policy identified infection prevention strategies during catheter care.	S3305		
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: KAR 26-41-207(c) The facility reported a census of 30 residents. The sample included three residents and eight abbreviated record reviews. 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.	S3310		

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S3310	Continued From page 49 26-39-105. This failure effected all residents who lived in the assisted living facility. Findings included: - Resident (R)1 moved into the facility on 03/01/25 with a diagnosis of Alzheimer's Disease. Review of R1's medical record revealed the first step of the two-step TB skin test (TST) was administered on 02/27/25 but was not read. The second step of the TST was not administered. On 08/28/25 at 09:00 AM Administrative Nurse C confirmed that TB records were not completed or were not obtainable at this time. The 06/2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "The first TST shall be read within 48-72 hours of its administration." The administrator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. -R5 moved into the facility on 06/29/23 with a diagnosis of dementia. Review of R5's medical record revealed a lack of documentation of a two-step TST and TB symptom screen questionnaire completed upon admission. On 08/28/25 at 09:00 AM Administrative Nurse C	S3310		

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S3310	Continued From page 50 confirmed that TB records were not completed or were not obtainable at this time. The 06/2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within 7 days of residency ...Each new resident ...shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of residency ..." The administrator 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 personnel records for five newly hired employees revealed the following: Certified Nursing Aide (CNA) G was hired on 06/09/24 and lacked documentation of a TB symptom screen questionnaire completed within seven days of hire. Certified Medication Aide (CMA) E was hired on 05/15/24 and lacked documentation of a TB symptom screen questionnaire completed within seven days of hire. CMA F was hired on 06/16/25 and lacked documentation of a TB symptom screen questionnaire completed within seven days of hire and had documentation of a previous TST completed on 11/15/24 which was more than six-months prior to hire.	S3310		

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S3310	Continued From page 51 CNA H was hired on 11/11/24 and lacked documentation of a TB symptom screen questionnaire completed within seven days of hire and had a two-step TST completed on 11/15/24 which was seven days late. CNA I was hired on 04/23/24 and lacked documentation of a TB symptom screen questionnaire completed within seven days of hire and did not have a two-step TST administered until 12/19/24 approximately eight months late. On 08/28/25 at 02:03 PM Administrative Nurse D confirmed staff records lacked documentation of TB symptom screen questionnaires completed. The 06/2013 "Tuberculosis (TB) Guidelines for 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 or an IGRA for Mycobacterium tuberculosis within 7 days of ...employment." The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		