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	N046104	A. BUILDING: _____ B. WING _____	02/26/2025

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BENTON HOUSE OF OLATHE	15700 W. 151ST STREET OLATHE, KS 66062

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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints #193548, #191321, #190965, #187442, and #180689 at the above named assisted living conducted on 02/25/25 and 02/26/25.	S 000		
S3026 SS=G	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 78 residents with six residents included in the sample and one closed record review. Based on observation, interview, and record review the administrator failed to protect Resident (R) 7 from neglect when he complained of foot pain and developed pressure sores on his feet; and failed to ensure licensed staff provided timely nursing assessment and documentation of the wound. Findings included: - Record review for R7 revealed an admission	S3026		

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

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date of 09/18/24 with a diagnosis of dementia.

The 01/12/25 "Functional Capacity Screen" (FCS) identified R7 required physical assistance with bathing, dressing, toileting, transfers, and walking/mobility; was unable to perform management of medications and treatments; was frequently incontinent of bladder; had short-term memory and impaired decision-making cognitive difficulties; was usually understood and sometimes understood others during communication; and was marked at risk for falls.

The 01/27/25 "Negotiated Service Agreement" (NSA) identified facility staff provided R7 full assistance with bathing; assistance each morning and evening with dressing and he wore long sleeves to protect his skin. Facility staff ensured R7 wore pressure-reducing, skin-protective, heel boots at all times. Facility staff provided assistance every two-to-three hours for toileting; assistance with transfers; propelled R7's wheelchair for walking/mobility; provided management of medications and treatments; provided reminders and encouragement and escort to activities for cognitive difficulties; and placed his bed against the wall and he had one-on-one sitter during the night to prevent injury from falls. A home health company provided management of bilateral heel wounds.

The 11/15/24 at 01:31 PM "Nurse Note" by Licensed Nurse C documented R7 cried from pain in his feet. The Certified Medication Aide (CMA) administered acetaminophen.

The 11/15/24 at 06:08 PM "Nurse Note" by CMA

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D documented R7 experienced "extreme level pain" in his feet during breakfast that morning. He was in so much pain he cried for some time. She took his shoes off and was not sure if they were too tight or if the pain was from other reasons.

The 01/07/25 at 09:39 PM "Nurse Notes" by CMA D documented R7 complained of foot pain. She took his socks off and noticed his feet were swollen and a there was a sore on the right side of his right foot. She notified the "PIC" (facility's charting abbreviation for person in charge) and administered first aid.

The 01/10/25 at 12:09 PM "Nurse Note" by Administrative Nurse F documented R7 had bilateral heel wounds, and she notified Advanced Registered Nurse Practitioner (ARNP) H who wrote new orders to refer R7 to a home health provider.

The 01/11/25 at 10:20 PM "Nurse Note" by CMA E documented the backs of R7's heels were black where the sores were. She dressed the sores with bandages and put "booties" on R7's feet per direction of Administrative Nurse F.

The 01/15/25 at 10:58 PM "Nurse Note" by Licensed Nurse G documented she cleaned and bandaged both wounds on R7's heels.

The 01/17/25 at 08:46 PM "Nurse Note" by CMA D documented R7 had increased pain in his left heel.

Review of R7's record from admission to 02/25/25 revealed lack of evidence of

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documentation of skin monitoring and interventions to prevent pressure wounds by licensed facility staff prior to pressure wounds and lacked evidence of documentation of the pressure wounds after they developed, including time of origin, type of wounds and locations, wound sizes (length, width, and depth), odor, tissue characteristics (including color, drainage, granulation), any signs of infection, pain, if a physician was informed, and a plan for treatment.

Review of R7's record revealed the following:

From 11/15/24 (when he first complained of foot pain) to 01/07/25 (first report of skin sore) was 53 days his record lacked evidence of documentation a licensed nursed assessed R7's feet after direct care staff reported he complained of pain and his feet were swollen and/or shoes and socks were too tight.

From 01/07/25 (first report of a skin sore) to 01/10/25 (when Administrative Nurse notified R7's PCP of skin sore) was three days his record lacked evidence of documentation a time of origin of skin wounds, type of wounds and locations, wound sizes (length, width, and depth), odor, tissue characteristics (including color, drainage, granulation), any signs of infection and/or pain, if R7's PCP was informed, and a plan for treatment.

From 01/10/25 (when orders R7's PCP wrote orders to refer to home health for wound care) to date of home health nurse's first visit on 01/16/25 was six days.

The 01/16/25 "Start of Care" notes by the home

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health nurse documented R7 had two pressure ulcers, one on each heel. The right heel pressure ulcer measured 4.5 by 5.5 cm and was unstageable due to eschar. The left heel pressure ulcer measured 3.5 by 2.9 centimeters (cm) and was 0.3 cm deep with no drainage and no odor.

The 02/24/25 "Visit Report" by a wound care specialist provider documented R7's right heel unstageable pressure injury measured 2.6 cm by 1.4 cm with no drainage. The left heel unstageable pressure injury measured 4.1 cm by 4.1 with no drainage. No improvement noted in wound progression. The wound had a strong odor suspicious of infection. The wound care specialist provider informed Administrative Staff A that R7's Primary Care Provider (PCP) needed to evaluate R7 to rule out osteomyelitis as the left heel was suspicious for infection. Administrative Staff A reported the ARNP would be in facility the next day and would inform her to evaluate R7.

Observation on 02/26/25 at 02:36 PM revealed R7 sat in a wheelchair in the common area of the memory care unit. He wore soft offloading boots on both feet.

On 02/26/25 at 02:49 PM CMA E stated R7 complained of foot pain after a shower when she applied lotion to his heel. She observed a white area of skin on his left heel with redness around it. His right heel appeared fine. She reported R7's complaint of pain and her observation to Administrative Nurse but could not recall the date.

On 02/26/25 at approximately 03:16 PM

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Administrative Staff A stated "PIC" in "Nurse Notes" stood for person in charge. The PIC in the building on the evening of 01/07/25 when facility staff first reported R7 had a foot sore was Licensed Nurse G.

On 02/26/25 at 03:22 PM via phone interview, Licensed Nurse G stated she could not recall if she looked at R7's feet when he first complained of pain. She looked at his feet later. If staff reported any resident complained of pain or had skin issues she looked at the resident's skin the same day and wrote a note about it. If it was a new sore, she notified the PCP by putting a note in the PCP's binder. The PCP came on Tuesday or Friday and would visit all the residents marked on their list.

On 02/26/25 at 03:34 PM Administrative Staff A confirmed R7's record lacked evidence of documentation of skin monitoring and interventions to prevent pressure wounds by licensed facility staff prior to pressure wounds and lacked evidence of documentation of the pressure wounds after they developed. Home health staff visited R7 three times a week to treat his wounds. She checked in his record on 02/24/25 and noticed a lack of documentation. She contacted the home health provider and requested they fax her recent visit notes as well as requested they check in with Administrative Nurse B at each visit. The home health nurse visited R7 that morning and reported to Administrative Nurse B about the visit.

On 02/27/25 at approximately 08:20 AM via phone interview, CMA D stated R7 began to complain of pain in his feet around Thanksgiving

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2024. His feet were swollen and sore. When she called the person in charge, they instructed her to administer acetaminophen. On 01/07/25 during her shift at the facility, R7 cried loudly in pain. She asked him what was wrong, and he said, "my feet, my feet." CMA D observed R7's shoes and socks appeared to be too tight. He had a small abrasion on the right side of his right foot about the size of a nickel. She sprayed the sore with wound cleaner, let it dry, applied an adhesive bandage, and notified the person in charge.

On 02/27/25 at approximately 08:30 AM via phone interview, ARNP H stated she first became aware of R7's foot sores on 01/10/25. He had pressure sores on both heels that were black. She wrote orders to refer to home health. He had developed infection, and she ordered antibiotics to treat it.

The facility's 05/15/05 "Resident Health Monitoring" policy documented facility staff would monitor each resident's health closely and document any change in physical condition.

The facility's 01/01/22 "Reporting Changes in Resident Condition" policy documented facility staff would bring to the attention of the resident services director or the person in charge any changes in a resident's condition. The resident services director or the person in charge would determine the severity of the change and contact the resident's physician.

The administrator failed to protect R7 from neglect by the failure to ensure licensed staff documented skin monitoring and interventions to

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S3026	Continued From page 7 prevent pressure wounds when R7 developed pressure areas on bilateral heels.	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) The facility reported a census of 78 residents with six residents included in the sample and one closed record review. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreements" (NSA) for Resident (R) 6 and R7 described the services they received based on their "Functional Capacity Screens" (FCS).	S3085		

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S3085	Continued From page 8 Findings included: - Record review for R6 revealed an admission date of 04/02/24 with a diagnosis dementia. The 12/23/24 "FCS" identified R6 was unable to perform management of medications and was rarely or never understandable and sometimes understood others during communication. The 12/23/24 "NSA" identified R6 was "currently not on any medications" and R6 "speaks in word salad" for communication. The "NSA" failed to describe services provided for management of medications and communication. On 02/26/25 at 02:36 PM Certified Nurse Aide (CNA) O stated R6 talked but did not really say anything. Staff met her needs by monitoring her body language and they could tell if something was wrong with her. On 02/26/25 at 02:49 PM Certified Medication Aide (CMA) E stated R6 talked but didn't mean anything and was not able to make her needs known. Staff met her needs by assisting her to toilet every 2-3 hours; they could tell she was in pain by watching her facial expressions; and R6 was able to tell staff if something hurt. R6 took her medications crushed in pudding and had always taken medications since moved in. On 02/26/25 at 04:06 PM Administrative Staff A confirmed designated staff administered R6 medications.	S3085		

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S3085	Continued From page 9 On 02/26/25 at 04:57 PM Administrative Staff A confirmed R6's "NSA" failed to describe services provided for management of medications and communication. The administrator failed to ensure the "NSA" for R6 described services provided for management of medications and communication. - Record review for R7 revealed an admission date of 09/18/24 with a diagnosis of dementia. The 01/12/25 "FCS" identified R7 was usually understood and sometimes understood others during communication. The 01/27/25 "NSA" failed to describe services provided for communication. On 02/26/25 at 02:49 PM CMA E stated R7 was able to talk and make his needs known. On 02/26/25 at 04:57 PM Administrative Staff A confirmed R7's "NSA" failed to describe services provided for communication. The administrator failed to ensure the "NSA" for R6 described services provided for communication. The 07/01/24 "Assessment/Service Plan General Guidelines" policy documented the assessment/service plan served as the foundational communication tool to outline services and levels of assistance the facility provided a resident. The administrator failed to ensure the "NSA's" for	S3085		

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S3085	Continued From page 10 R6 and R7 described the services they received based on their "FCS's."	S3085		
S3105 SS=D	26-41-202 (j) Negotiated Service Agreement Outside Resource (j) If a resident's negotiated service agreement includes the use of outside resources, the designated facility staff shall perform the following: (1) Provide the resident, 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, with a list of providers available to provide needed services; (2) assist the resident, if requested, in contacting outside resources for services; and (3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice This REQUIREMENT is not met as evidenced by: KAR 26-41-202(j)(3) The facility reported a census of 78 residents with six residents included in the sample and one closed record review. Based on interview and record review the administrator failed to ensure designated staff monitored services provided by outside resources for resident (R) 7 when nursing staff failed to ensure wound care providers documented assessments, treatments and outcomes concerning R7's pressure wounds.	S3105		

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S3105	Continued From page 11 Findings included: - Record review for R7 revealed an admission date of 09/18/24 with a diagnosis of dementia. The 01/12/25 "Functional Capacity Screen" (FCS) identified R7 was unable to perform management of treatments. The 01/27/25 "Negotiated Service Agreement" (NSA) identified facility staff ensured R7 wore pressure-reducing, skin-protective, heel boots at all times. A home health company provided management of bilateral heel wounds. The 01/10/25 at 12:09 PM "Nurse Note" by Administrative Nurse F documented R7 had bilateral heel wounds, and she notified Advanced Registered Nurse Practitioner (ARNP) H who wrote new orders to refer R7 to a home health provider. On 02/26/25 at 03:34 PM Administrative Staff A stated home health visited R7 three times a week to treat his wounds. She confirmed his record lacked evidence of documentation a licensed nurse staff ensured wound care providers documented assessments, treatments and outcomes concerning R7's pressure wounds. The 06/05/09 facility's "Maximizing the Contributions of Third Party Providers" policy did not address facility monitoring outside providers for professional standards of practice. The administrator failed to ensure designated staff monitored the services provided by outside	S3105		

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S3105	Continued From page 12 resources concerning R7's pressure wounds.	S3105		
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 78 residents with six residents included in the sample and one closed record review. Based on observation, interview, and record review the administrator failed to ensure a licensed nurse provided the necessary health care services to keep cognitively impaired Residents (R) 3 and R4 safe from exiting the facility. Findings included: - Record review for R3 revealed an admission date of 05/09/23 with a diagnosis of Alzheimer's disease. The 10/22/24 "Functional Capacity Screen"	S3155		

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(FCS) identified R3 was independent with transfers and walking/mobility; had short-term and long-term memory, memory/recall, and impaired decision-making cognitive difficulties; and was marked for wandering.

The 10/22/24 "Negotiated Service Agreement" (NSA) identified facility staff provided R3 reminders to use her walker while ambulating; repeat reminders as necessary for cognitive difficulties; and she moved to a secured memory care unit for wandering behavior.

The 10/23/24 facility's "Investigation Report" to the department documented on 10/20/24 at approximately 06:20 AM Licensed Nurse C noticed R3 walking in the hallway and redirected her to back to bed. At approximately 06:30 AM Licensed Nurse C found R3's door was open and began to look for R3. Licensed Nurse C found R3 outside of the facility on the ground in the back parking lot and assisted her back inside the facility.

On 02/25/25 at 12:36 PM Administrative Staff A stated R3 lived in the assisted living side of the building when exited the facility on 10/20/24. She had suffered a decline in cognitive status with increase confusion and moved to the memory care unit on 10/21/24.

The administrator failed to ensure a licensed nurse provided the necessary health care services to keep R3 safe from exiting the building.

- Record review for R4 revealed an admission date of 07/05/24 with a diagnosis of short-term

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S3155	Continued From page 14	S3155		

memory loss.

The 10/02/24 "FCS" identified R4 was independent with transfers and walking/mobility; had short-term and long-term memory, memory/recall, and impaired decision-making cognitive difficulties; and was marked for wandering.

The 10/02/24 "NSA" identified facility staff provided R4 redirection to a secured courtyard so he could walk independently; escort to families to exit to ensure he did not follow someone out of the building; 30-minute visual checks while he was awake; engagement in activities and events for wandering behavior.

The 10/08/24 facility's "Investigation Report" to the department documented on 101/02/24 at approximately 12:45 PM R4 followed another resident's family member out the exit door. When the family member realized R4 followed her out, she returned inside to report R4 was outside the facility. All available staff went outside to circle the building to look for R4. Staff found him approximately 10 minutes later about one block from the facility.

On 02/25/25 at 12:30 PM Administrative Staff A stated R4 exited the facility during a time families knew the keypad code to use to exit the memory care unit. He was outside unsupervised for 10 minutes. Families no longer have the code. Staff escort family members and enter the code for them to exit the memory care unit.

The administrator failed to ensure a licensed nurse provided the necessary health care

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S3155	Continued From page 15 services to keep R4 safe from exiting the building. The 06/03/20 facility's "Missing Resident/Elopement: Prevention, Preparedness and Intervention" policy documented designated staff would regularly evaluate residents for elopement risk prior to admission, quarterly, and after significant change in condition. The administrator failed to ensure a licensed nurse provided the necessary health care services to keep cognitively impaired R3 and R4 safe from exiting the facility.	S3155		
S3175	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually.	S3175		

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S3175	Continued From page 16 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 78 residents with six included in the sample. Based on interview and record review the administrator failed to ensure a licensed nurse performed an assessment to determine if Resident (R) 3 and R8 could self-administer insulin safely. Findings included: - Record review for R3 revealed an admission date of 05/09/23 with diagnoses of Alzheimer's Disease and type one diabetes mellitus. The 10/22/24 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with management of medications. The 10/22/24 "NSA" identified facility staff administered medications and R3 received an insulin injection. The "NSA" failed to identify who administered insulin. On 02/25/26 at 04:33 PM Administrative Nurse B stated R3 administered her own insulin after the Certified Medication Aide (CMA) dialed the pen. R3's record lacked evidence of documentation a licensed nursed completed a medication self-administration assessment. The administrator failed to ensure a licensed nurse performed an assessment to determine if R3 could self-administer insulin safely.	S3175		

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S3175	Continued From page 17 - Record review for R8 revealed an admission date of 08/30/24 with a diagnosis of type two diabetes mellitus. The 11/12/24 "FCS" identified R8 required physical assistance with management of medications. The 11/12/24 "NSA" identified facility staff administered all medications. The "NSA" failed to identify who administered insulin. On 02/25/26 at 04:33 PM Administrative Nurse B stated R8 administered her own insulin after the Certified Medication Aide (CMA) dialed the pen. The 03/14/12 facility's "Medication Management General Guidelines" policy documented a resident may be assisted and supervised with injections if allowed by state law were to be reviewed and approved with the Regional Director prior to implementation. The policy did not address a licensed nurse must assess residents before they self-administer medication. The administrator failed to ensure a licensed nurse performed an assessment to determine if R3 and R8 could self-administer insulin safely. On 01/29/25 at approximately 03:35 PM Administrative Nurse C confirmed R8's record lacked evidence of documentation a designated licensed nurse completed a medication self-administration assessment. The undated facility's "Self-Administration of Medication Policy" documented if a resident wished to self-administer medications, an	S3175		

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S3175	Continued From page 18 assessment must be performed on admission, readmission, every six months, and with significant changes as needed to ensure the resident could safely self-administer medications The administrator failed to ensure a licensed nurse performed an assessment to determine if R8 could self-administer insulin safely.	S3175		
S3186 SS=E	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(b) The facility reported a census of 78 residents with six residents included in the sample and one closed record review. Based on interview and record review the administrator failed to ensure "Negotiated Service Agreements" (NSA) for Resident (R) 3 and R8 identified who was responsible for the administration and management of select medications for insulin.	S3186		

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S3186	Continued From page 19 Findings included: - Record review for R3 revealed an admission date of 05/09/23 with diagnoses of Alzheimer's Disease and type one diabetes mellitus. The 10/22/24 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with management of medications. The 10/22/24 "NSA" identified facility staff administered medications and R3 received an insulin injection. The "NSA" failed to identify who administered insulin. On 02/25/26 at 04:33 PM Administrative Nurse B stated R3 administered her own insulin after the Certified Medication Aide (CMA) dialed the pen. On 02/26/25 at 03:58 PM Administrative Staff A confirmed R3's "NSA" failed to identify who administered insulin. The administrator failed to ensure R3's "NSA" identified who was responsible for the administration and management of select medications. - Record review for R8 revealed an admission date of 08/30/24 with a diagnosis of type two diabetes mellitus. The 11/12/24 "FCS" identified R8 required physical assistance with management of medications. The 11/12/24 "NSA" identified facility staff	S3186		

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S3186	Continued From page 20 administered all medications. The "NSA" failed to identify who administered insulin. On 02/25/26 at 04:33 PM Administrative Nurse B stated R8 administered her own insulin after the Certified Medication Aide (CMA) dialed the pen. On 02/26/25 at 03:58 PM Administrative Staff A confirmed R8's "NSA" failed to identify who administered insulin. On 02/26/25 at 04:45 PM R8 stated she self-administered her own insulin. The administrator failed to ensure R8's "NSA" identified who was responsible for the administration and management of select medications. The 03/14/12 facility's "Medication Management General Guidelines" policy documented a resident may be assisted and supervised with injections if allowed by state law were to be reviewed and approved with the Regional Director prior to implementation. The policy did not address select medications. The administrator failed to ensure R8's "NSA's" identified who was responsible for the administration and management of select medications.	S3186		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A	S3211		

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S3211	Continued From page 21 licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 78 residents. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of five over-the-counter (OTC) medications. Findings included: - Observation on 02/25/25 at 12:45 PM revealed Certified Medication Aide (CMA) I unlocked and opened medication cart #1. The following OTC medications lacked residents' full names: One bottle of loratadine 10 milligrams (mg), 200 tablets One bottle of Vitamin Code Men's multivitamins 240 capsules On 02/25/25 at approximately 12:45 PM	S3211		

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S3211	Continued From page 22 Administrative Staff A confirmed two OTC medications in medication cart #1 lacked residents' full names. On 02/25/25 at approximately 01:49 PM CMA J opened and unlocked and opened the memory care unit #2 medication cart. The following OTC medications lacked residents' full names: One bottle of vitamin B-12 2500 micrograms (mcg), 300 tablets One 16-ounce bottle of Calm magnesium supplement One box of Allegra 60 mg, 12 tablets On 02/25/25 at approximately 01:49 PM Administrative Staff A confirmed three OTC's in memory care unit #2 medication cart lacked residents' full names. The 03/14/12 facility's "Medications Brought to the Community by Resident, Family Members, or Non-Preferred Pharmacy" policy documented medications brought to the community were allowed only when the container was clearly labeled. The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of five OTC medications.	S3211		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following:	S3280		

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S3280	Continued From page 23 (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 78 residents. Based on interview and record review the administrator failed to provide evidence of documentation designated staff provided reviews of the facility's emergency management plan with residents every quarter. Findings included: - On 02/25/25 at 12:13 PM the facility's records for quarterly reviews of the emergency management plan were requested by email. On 02/25/25 at 02:59 PM Administrative Staff A confirmed facility records lacked evidence of documentation designated staff provided reviews	S3280		

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S3280	Continued From page 24 of the facility's emergency management plan with residents every quarter. The 06/03/15 facility's "Disaster Plan" policy documented all employees and residents would be prepared for disasters which could affect the community. The administrator failed to provide evidence of documentation designated staff provided reviews of the facility's emergency management plan with residents every quarter.	S3280		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility reported a census of 78 residents. The facility had a main kitchen where dietary staff stored, prepared, and served food and two satellite kitchens where staff stored and served food. Based on observation and interview the administrator failed to ensure designated staff stored food items under safe conditions. Findings included:	S3299		

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S3299	Continued From page 25 - Observation on 02/25/25 at PM 01:15 PM of memory care unit #1 revealed a satellite kitchen with a refrigerator containing food items for the residents. The refrigerator had one plastic pitcher of what appeared to be orange juice that lacked a cover and label with a prepared date. On 02/25/25 at approximately 01:15 PM Administrative Staff A confirmed one pitcher in the memory care unit #1 refrigerator contained a pitcher of juice for the resident's that lacked a cover and label with a prepared date. Observation on 02/25/25 at PM 01:31 of memory care unit #2 revealed a satellite kitchen with a refrigerator containing food items for the residents. The refrigerator contained one half-gallon container of Silk almond milk dated 01/30/25 which was 26 days on date of survey and one eight-ounce (oz) container of fresh mushrooms that appeared dark brown and slimy. The refrigerator also contained the following items that lacked opened or prepared dates: Five clear pitchers of prepared juice One 32-oz bottle of opened prune juice One 20-oz bottle of opened Gatorade On 02/25/25 at approximately 01:31 PM Administrative Staff A confirmed five food items in the memory care unit #2 lacked opened or prepared dates, had Silk almond milk passed a safe use date, and fresh mushrooms that appeared rotten. The 06/08/08 facility's "Kitchen Sanitation" policy documented a person would complete assigned tasks and initial when completed on the "Daily	S3299		

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S3299	Continued From page 26 Kitchen Cleaning Checklist" form. The "Daily Kitchen Cleaning Checklist" form listed several tasks which included "properly label and package leftovers." The administrator failed to ensure designated staff stored food items under safe conditions.	S3299		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s 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 78 residents with six residents included in the sample and one closed record review. Based on interview and record review the administrator failed to ensure the facility remained in compliance with the	S3310		

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S3310	Continued From page 27	S3310		

department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for one resident and five of five sampled staff.

Findings included:

- Record review for Resident (R) 8 revealed an admission date of 08/30/24 with a diagnosis of diabetes mellitus type two.

The 10/21/24 first step of a two-step TB skin test was negative which was 52 days after admission. R8's record lacked evidence of documentation designated staff provided a TB skin test within seven days of admission.

On 02/26/25 at 04:03 PM Administrative Staff A confirmed R8's record lacked evidence of documentation designated staff provided a TB skin test within seven days of admission.

- Review of Licensed Nurse K's employee record revealed a hire date of 12/09/24. The 11/19/24 first step of a two-step TB skin test was negative. Her record lacked evidence of documentation she completed a second-step of the two-step TB skin test and a TB symptom screen questionnaire within seven days of hire.

Review of Certified Medication Aide (CMA) J's employee record revealed a hire date of 12/10/24. Her record lacked evidence of documentation she completed a two-step TB skin test and a TB symptom screen questionnaire within seven days of hire.

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S3310	Continued From page 28 Review of CMA L's employee record revealed a hire date of 08/06/24. Her record lacked evidence of documentation she completed a two-step TB skin test and a TB symptom screen questionnaire within seven days of hire. Review of Certified Nurse Aide (CNA) M's record revealed a hire date of 01/09/25. Her record lacked evidence of documentation she completed a two-step TB skin test and a TB symptom screen questionnaire within seven days of hire. Review of CNA N's employee record revealed a hire date of 08/30/24. His record lacked evidence of documentation she completed a two-step TB skin test and a TB symptom screen questionnaire within seven days of hire. On 02/25/25 at approximately 04:30 PM Administrative Staff A confirmed five sampled employees' record's lacked evidence of documentation they completed two-step TB skin tests and a TB symptom screen questionnaires within seven days of hire. The 11/01/17 facility's "Screening for Tuberculosis" policy documented the facility would follow state guidelines regarding tuberculosis screening. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee and each new resident shall receive a two-step TB skin test and symptom screen questionnaire within seven days of employment or admission.	S3310		

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S3310	Continued From page 29 The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		