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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 05-11-21, 05-12-21, 05-13-21, 05-17-21 and 05-18-21.	S 000		
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) The facility reported a census of 39 residents. The sample included 3 residents and 1 focused review. Based on interview and record review the administrator failed to ensure the written negotiated service agreement for 3 of 4 residents (#745, #922 and #948) included a description of the services the resident would receive with	S3085		

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

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S3085	Continued From page 1	S3085		

identification of the provider for each service.

Findings included:

- Record review for resident #745 revealed an admission date 03-03-2020 with diagnoses of Alzheimer's disease, mixed anxiety, major depressive disorder and poly-osteoarthritis.

The annual functional capacity screen (FCS) dated 03-03-21 identified the resident with impaired cognition in all aspects. She needed physical assistance with bathing and dressing, supervision for toileting and independent with transfers, walking and eating. She displayed socially inappropriate behaviors and had impaired decision making.

The negotiated service agreement/health service plan (NSA/HSP) dated 03-03-21 directed staff to provide physical assistance with bathing, supervision with dressing and toileting. The resident is independent with transfers, mobility and walking. Facility staff would prepare meal which the resident would eat independently. Facility staff to provide housekeeping and laundry services. The facility staff would manage the resident's medications and treatments. Under the section for mental status licensed nurse A marked the resident as oriented to person, place and time with mild impairment and the comment portion was blank. The resident can make her needs known to staff. The NSA/HSP included under the section for therapy-TMC PRN (as needed) as ordered-paid by Medicare/Medicaid/private insurance ad private pay. The NSA/HSP lacked a revision/amendment when the resident actually started therapy services

Review of the medical care provider's orders

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S3085	Continued From page 2 revealed an order on 04-20-21 for PT/OT (physical and occupational therapy) to evaluate and treat for unsteadiness. The electronic record indicated PT and OT began on 05-03-21. Interview on 05-17-21 with licensed nurse A confirmed the NSA/HSP lacked a revision/amendment when the resident started on therapy services to include a description of the services. The administrator failed to ensure the written negotiated service agreement for resident #745 included a description of the services the resident received. - Record review on 05-12-21 at for resident #922 revealed an original admission date of 12-07-2018 and admitted to the memory care unit on 11-08 2019 with diagnosis of Alzheimer's disease. The annual functional capacity screen (FCS) dated 01-21-21 identified the resident with impaired cognition in all aspect, impaired decision-making, wandering behavior and required physical assistance with all activities of daily living except for eating. The negotiated service agreement/health care plan (NSA/HSP) dated 01-21-21 directed staff to provide the resident with physical assistance for bathing, dressing, and toileting. Under the section for therapy-PT/OT/ST as ordered by primary care provider, paid for by private pay and private insurance. The NSA/HSP lacked any revisions between 01-21-21 and 04-14-21.	S3085		

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S3085	Continued From page 3 According to medical care provider's orders and interview with the staff the resident received services from an outside provider of physical therapy at the end of February 2021. Review of the medical care provider's (MCP) orders revealed an order dated 02-18-21 of physical therapy for balance/weakness - eval and treat. Review of the interdisciplinary progress notes (IDPN) revealed an entry dated 01-20-21 at 3:00 PM of a fall the resident had onto her bottom in the living room. An entry on 02-18-21 at 4:16 PM which indicated the resident was seen by a medical care provider with new orders for PT due to balance and weakness and the outside provider for therapy was notified of the order. There was no revision to the NSA to show PT was started. The IDPN lacked any information about the starting of PT. Interview on 05-12-21 at 1:15 PM with direct care staff B and licensed nurse A confirmed the resident received services from an outside provider for physical therapy at the end of February 2021 first part of March 2021. Licensed nurse A confirmed the NSA/HSP lacked a revision/amendment which include a description of the services being provided by an outside provider. The administrator failed to ensure the written negotiated service agreement for resident #922 included a description of the services the resident received with identification of the provider for each service and the party responsible for payment when outside resources provide a service.	S3085		

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S3085	Continued From page 4 - Record review for resident #948 revealed an admission date of 06-13-2019 with diagnoses of diabetes type 2 and hypertension. The annual functional capacity screen dated 06-24-2020 identified the resident with a deficit in memory recall. He was independent with activities of daily living. The negotiated service/health service plan (NSA/HSP) dated 06-24-2020 under therapy section-TMC to eval and treat as indicated and per physician's orders. Charges all other charges covered by Medicare/Medicaid/Private pay/Private insurance. Review of the interdisciplinary progress notes revealed the resident had a fall on 03-29-21 following a period of illness. On 04-02-21 the medical care provider ordered PT/OT (physical and occupational therapy) to evaluate and treat. Electronic record review revealed the resident received PT/OT services which began on 04-22-21. The NSA/HSP lacked a revision/amendment to reflect the addition of an outside provider with a description of the services the resident received. On 05-13-21 licensed nurse F confirmed the NSA/HSP lacked a revision/amendment when the resident started with outside services of PT/OT. The administrator failed to ensure the written negotiated service agreement for resident #922 included a description of the services the resident received with identification of the provider for each service and the party responsible for payment when outside resources provide a	S3085		

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S3085	Continued From page 5 service.	S3085		
S3155 SS=G	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: K.A.R. 26-41-204 (a) The facility reported a census of 39 residents. The sample included 3 residents and 1 focused review. Based on observation, record review and interview the administrator failed to ensure a licensed nurse provided or coordinated 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 for 3 of 4 sampled residents in regards to falls, functional ability decline, pressure ulcer prevention and to promote healing, socially inappropriate behavior and wandering behavior (#745, #826 and #922). Resident #922 had a decline in functional abilities then had a fall with a fracture on 04-14-21 further reducing her abilities, a licensed nurse failed to develop interventions to reduce the risk of pressure ulcer development. Resident #922	S3155		

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S3155	Continued From page 6 developed a deep tissue injury across her buttocks on 04-26-21 (presenting as dark purple in color) which measured 1 centimeter (cm) by 1 cm and an open area on the right buttocks which measured 0.5 cm by 0.5 cm. On 04-28-21 the nurse obtained a medical provider's order for home health services to manage the wound. The home health service first visited on 05-03-21 noted the resident now had 3 open areas (1 at the intergluteal cleft which measured 2 cm by 2 cm, 1 next to it which measured 1 cm by 1 cm and 1 above that which measured 1.5 cm by 1 cm. Findings included: - Record review on 05-12-21 at for resident #922 revealed an original admission date of 12-07-2018 and admitted to the memory care unit on 11-08 2019 with diagnosis of Alzheimer's disease. The annual functional capacity screen (FCS) dated 01-21-21 identified the resident with impaired cognition in all aspect, impaired decision-making, wandering behavior and required physical assistance with all activities of daily living except for eating. She lacked the ability to manage her own medications or treatments and was at risk for falls. The negotiated service agreement/health care plan (NSA/HSP) dated 01-21-21 directed staff to provide the resident with physical assistance for bathing, dressing, and toileting. Under transfers, mobility and walking licensed nurse A marked the resident needed supervision/cueing and not the physical assistance identified on the FCS. Noted under transfers was the resident needed verbal cues to help remind her of what she needed to do	S3155		

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and where to go. Licensed nurse A under mobility/walking failed to mark the resident as a fall risk and under the comments nurse A wrote the resident was independent with no appliances but needed cues to where she is going and what she needed to do. The NSA health care plan lacked any interventions to reduce the risk for falls which were identified on the FCS.

The NSA/HSP lacked any revisions between 01-21-21 and 04-14-21 when the resident had to be moved to the neighboring house for a remodel. An amendment on 04-15-21 for the resident to wear a sling on the left arm at all times due to a left clavicle fracture and to use a wheelchair for long distances due to unsteady gait. An amendment on 04-29-21 for the resident to begin receiving home health for wound care, PT (physical therapy) and OT (occupational therapy).

The NSA/HSP lacked revision/amendment after the fall on 04-14-21 or after the discovery of pressure ulcers on 04-26-21.

Review of the medical care provider's (MCP) orders revealed the following orders: 02-18-21 physical therapy for balance/weakness - eval and treat. A fax sent on 04-08-21 and signed by the MCP on 04-09-21 included per family's request may we have an order for OT to eval and treat for upper extremity strengthening, dressing, ADLs (activities of daily living) and feeding to which the MCP wrote yes for the above.

Review of the interdisciplinary progress notes (IDPN) between 11-01-2020 and 05-11-21 (last entry and the time of the review) revealed the following entries:
On 01-20-21 at 3:00 PM the resident a fall had

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onto her bottom in the living room.
On 02-18-21 at 4:16 PM which indicated the resident was seen by a medical care provider with new orders for PT due to balance and weakness and the outside provider for therapy was notified of the order. There was no revision to the NSA to show PT was started. The IDPN lacked any information about the starting of PT. The next entry was made by dietary as their annual review of the resident's nutritional status.

The next entry was dated 04-12-21 regarding an order received from a medical care provider for OT to evaluate and treat per family's request. The record lacked evidence of OT evaluation or start of services until 04-29-21.

On 04-14-21 at approximately 6:45 PM licensed nurse A received notification from staff of finding the resident in her room, on the floor and on her left side. When nurse A entered the resident's room the residents stated I think it's broken. After this nurse assessed range of motion and noted no pain from this resident the nurse and CMAs (certified medication aide) assisted the resident to her feet. The resident should know signs of symptoms of pain at that time. At approximately 7:00 PM the nurse was contacted again by the CMA stating the resident was noted to be holding her left arm. Nurse A went into assess the resident and noted her left neck and shoulder area was swollen. ... The resident went by EMS (emergency medical services) at 7:15 PM. On 04-14-21 at 10:05 PM licensed nurse A was notified by a CMA on duty that the emergency room had called stating the resident had a closed fracture to her clavicle She was ready to be picked up with the following new orders of a sling at all times to the left arm, pain management with a controlled substance as needed for 3 days and

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to follow up with an orthopedic doctor. The resident returned to the facility by facility transport. Staff noted the resident tolerating the sling well. Staff assisted the resident to bed.

The next entry was dated 04-19-21 at 3:08 PM marked as a late entry) which indicated the resident was seen this date by a DPT (Doctor of Physical Therapy) for a left clavicle fracture. Orders received-she is not allowed to use that arm at all, but she can go ahead and do the occupational therapy as ordered.

The handwritten orders by the DPT on 04-19-21 included; please make sure to place pillows under her left forearm to help protect her clavicle fracture. Patient is not allowed to perform movement of her left shoulder but is allowed to walk and perform lower extremity exercises.

Note-no revisions or amendments were made to the NSA/HSP directing staff on how to care for this resident who had a change in her functional abilities.

The IDPN go from 04-19-21 at 3:08 PM to 04-26-21 at 1:15 PM when licensed nurse A wrote red area found on resident's coccyx area which measured 11 cm by 9 cm across both buttocks. On the left buttock there is a dark purple in color area measuring 1 cm by 1 cm, on the right buttocks there is a small open area measuring 0.5 cm by 0.5 cm. Licensed nurse A noted the areas to be blanchable. ... a proximel dressing (a 5-layer silicone foam dressing) applied and awaiting orders for home health at this time.

No revisions or amendments were made to the NSA/HSP to address the development of the pressure ulcers, interventions to promote healing

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or reduce the risk of further development.

The next entry was by the pharmacist for the drug regiment review.
The next entry was dated 4/28/21 at 12:04 PM received orders for home health, PT and OT to evaluate and treat with fax sent to the outside provider home health company.
The next note was dated 05-03-21 at 8:33 AM (marked as a late entry) home health licensed nurse in this date to assess and measure the areas to the right buttocks. The resident has 3 open areas today (previously only had 1 open). The lower open area very close to the intergluteal cleft measured 2 cm by 2 cm, the open area next to it measured 1 cm by cm and the open area above measured 1.5 cm by 1 cm. The skin all around is red with some dark patches of skin areas.

The NSA/HSP remained without any revisions or amendments related to fall risks and the development of pressure ulcers at the time of the review on 05-12-21.

Observation on 05-12-21 at 1:00 PM revealed direct care staff B and C propelled the resident in a wheelchair from the dining room to her room. Direct care staff B placed a gait belt around the resident's waist. Direct care staff B and C used the gait belt to help the resident stand, pivot and sit on the bed. Staff B assisted the resident to lie down by holding her shoulders and staff C lifted the resident's feet onto the bed. Once the resident was in bed staff assisted her to roll onto her left side for incontinent care. Observation revealed 3 open areas on the right buttock which appear to be the same size as the measurements on 05-03-21 and an open area on the left which appears to be 2 open areas merged together and

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about 3 cm in diameter. The entire coccyx area and on both sides of the cleft appear to be a darker pink than her normal skin color and in places an even darker pink color. In the resident's recliner and wheelchair were pressure reducing cushions. Neither of the direct care staff could say when the cushions were put into place.

Interview on 05-12-21 at 1:10 PM with direct care staff B revealed the resident mostly just sat in her recliner after the fall and did not want to do much. She said the resident was able to transfer herself, walk about, get in/out of bed by herself before the fall.

Interview on 05-12-21 at 1:15 PM with licensed nurse A confirmed the resident had a history of falling and the NSA/HSP lacked identification of the fall risk or interventions to reduce her risks of falling. She confirmed the only NSA/HSP amendments were the ones dated 04-14-21 (room change), 04-15-21 (need for a sling and to use a wheelchair) and 04-29-21 (home health for wound care, PT/OT). She confirmed the resident needed more ADL assistance after the fall. She confirmed she failed to provide the staff with written directions for the resident's increased care needs. She did not know when the recliner and wheelchair cushions were implemented and had no documentation to show the implementation. She did not know why PT services stopped after 02-18-21 or why it took so long to get the services started. She had evidence of repeated communications with the therapy provider. She confirmed the pressure ulcers worsened before home health and therapy services began. She reported staff allowed the resident to remain in the recliner without repositioning and the believed the pressure ulcers were avoidable had staff repositioned the resident.

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S3155	Continued From page 12 The administrator failed to ensure a licensed nurse provided or coordinated 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 for resident #922 in regard to falls, functional ability decline, pressure ulcer prevention and to promote healing after development. Resident #922 had a decline in functional abilities, then had a fall with a fracture on 04-14-21 further reducing her abilities, a licensed nurse failed to develop interventions to reduce the risk of pressure ulcer development. Resident #922 developed a deep tissue injury across her buttocks on 04-26-21 (presenting as dark purple in color) which measured 1 cm by 1 cm and an open area on the right buttocks which measured 0.5 cm by 0.5 cm. On 04-28-21 the nurse obtained a medical provider's order for home health services to manage the wound. The home health service first visited on 05-03-21 noted the resident now had 3 open areas (1 at the intergluteal cleft which measured 2 cm by 2 cm, 1 next to it which measured 1 cm by 1 cm and 1 above that which measured 1.5 cm by 1 cm. - Record review for resident #745 revealed an admission date 03-03-2020 with diagnoses of Alzheimer's disease, mixed anxiety, major depressive disorder and poly-osteoarthritis. The annual functional capacity screen (FCS) dated 03-03-21 identified the resident with impaired cognition in all aspects. She needed physical assistance with bathing and dressing, supervision for toileting and independent with transfers, walking and eating. She displayed	S3155		

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socially inappropriate behaviors and had impaired decision making.

The negotiated service agreement/health service plan (NSA/HSP) dated 03-03-21 directed staff to provide physical assistance with bathing, supervision with dressing and toileting. The resident is independent with transfers, mobility and walking. Facility staff would prepare meal which the resident would eat independently. Facility staff to provide housekeeping and laundry services. The facility staff would manage the resident's medications and treatments. Under the section for mental status licensed nurse A marked the resident as oriented to person, place and time with mild impairment and the comment portion was blank. The resident can make her needs known to staff. The NSA/HSP did not include any outside service providers for behavioral management. The section for additional interventions was blank. The NSA/HSP lacked any identification of the resident socially inappropriate behaviors or directions to staff on how to manage the resident's behaviors.

Review of the interdisciplinary progress notes (IDPN) revealed the resident displayed socially inappropriate behaviors off and on since 04-14-2020 with documented inpatient stay at a behavioral unit. Recent notes reflect behaviors as follows:
On 11-08-21 at 12:30 PM the resident approached another resident accusing that resident of stealing her jacket ... the resident's voice got louder and louder ... when staff tried to intervene the resident struck the staff member in the face and stomach.
On 03-26-21 at 1:15 PM (marked as a late entry) licensed nurse A exiting from the dining room into the hallway the resident came walking towards

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S3155	Continued From page 14 the nurse with her hands into fist and the resident raised a hand back as if to hit the ... On 03-29-21 at 1:25 PM a family member voiced concerns of the resident possibly hallucinating ... resident talking about bugs, resident reach down and picked up a piece of fuzz from the carpet. On 03-29-21 at 4:00 PM licensed nurse A contacted the resident's responsible party and discussed some concerns with this resident and her roommate. The note failed to include specifics of the concern. The resident's responsible party requested a room change due to the 2 residents arguing. On 04-12-21 at 9:37 AM the resident got angry with staff and threw her plate on their table ... On 05-05-21 at 1:34 PM housekeeping staff reported the resident was rude and ripping items out of staff's hands when the housekeeping staff attempted to clean the room ... On 05-05-21 at 3:29 PM an outside provider reported was being mean to other residents and tried to hit other residents. The resident tried to hit the outside provider with a sensory box and was difficult to redirect. On 05-05-21 at 4:28 PM licensed nurse A called and spoke with the resident's responsible party regarding the resident's behaviors ... resident had attempted to attack three individuals today, and one was a resident. ... licensed nurse A informed the resident's responsible party of the resident's needing one on one and requested that her or another family member come to the building and do that for her or may take her to stay with them. ... On 05-08-21 at 3:56 PM resident refusing medications and cares with her fist raised as if to strike staff. Observation on 05-12-21 at approximately 12:45 PM cries from the resident's room were heard.	S3155		

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S3155	Continued From page 15 The room door was closed, upon knocking licensed nurse A opened the door and reported staff were caring for the resident. A few minutes later 3 staff exited the room with the resident. Direct care staff B held the resident's right arm firmly and direct care staff D had the left arm. Both staff were attempting to walk the resident towards the dining room. The resident was resisting care, had angry facial expression and said some words which were not distinguishable. When staff got her to the dining room which was full of other residents the resident began resisting again which required both staff to maneuver her through the dining room to the TV area. Interview with licensed nurse/administrator E on 05-17-21 confirmed the resident's FCS dated 03-03-21 identified the resident with socially inappropriate behaviors and the NSA/HSP dated 03-03-21 lacked identification of the resident's care needs, services to be provided or directions to staff on how to manage the resident's behaviors. The administrator failed to ensure a licensed nurse provided or coordinated 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 for resident #745 regarding socially inappropriate behaviors. - Record review for resident #826 revealed the resident originally admitted to the non-memory care house on 05-20-2020 and was not at risk for falls or elopement. She had diagnoses of hypertension, atrial fibrillation, chronic kidney disease and muscle weakness in the lower extremities.	S3155		

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S3155	Continued From page 16 According to the interdisciplinary progress notes the resident had an elopement on 08-17-2020 and was moved to the memory care unit. The functional capacity screen (FCS) completed on admission to the memory care unit and dated 08-18-2020 identified the resident with cognitive impairment in all aspects, wandering behavior and impaired decision making. She needed supervision with all activities of daily living. She was not marked as a fall risk at this time. An elopement risk assessment dated 08-18-2020 identified the resident as a high risk for elopement. The negotiated service agreement/health service plan (NSA/HSP) date 08-18-2020 directed staff to provide supervision with all activities of daily living and facility staff would manage her medications/treatments. Under the section for mental status licensed nurse A marked the resident had mild impairment and under the comments typed alert/oriented in 2 aspects (did not specify) with confusion noted. Under the section for additional interventions licensed nurse typed the resident is alert/oriented in 2 aspects with confusion noted at all times, resident is independent but needs assistance at times if weak or ill. Resident enjoys participating in activities and spending time with others. The NSA/HSP lacked identification of her elopement risk or interventions to reduce this risk. Review of the interdisciplinary progress notes (IDPN) revealed on 02-27-21 at 10:56 AM staff found the resident on the floor between the bedroom and bathroom. She had a skin tear on	S3155		

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S3155	Continued From page 17 her left arm, a cut above the right eyebrow and a big bump on her knee. The IDPN lacked any identification for causal factors of the fall or interventions developed to reduce the risk for further falls. The NSA/HSP lacked a revision related to the fall. On 04-20-21 at 11:00 AM staff found the resident on the floor beside her bed. The resident said she had fallen off the bed while sleeping. The IDPN lacked any indication for the causal factors or interventions developed to reduce the risk for further falls. The NSA/HSP lacked a revision related to the fall. On 05-13-21 licensed nurse A confirmed the NSA/HSP lacked identification and interventions to address the resident's wandering behaviors, no further investigation into causal factors of the 2 falls and that the NSA/HSP lacked revision/amendment with each fall to reduce the risk for further falls. The administrator failed to ensure a licensed nurse provided or coordinated 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 for resident #826 regarding wandering/exit seeking behaviors and falls.	S3155		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the	S3200		

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S3200	Continued From page 18 administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (d) The facility reported a census of 39 residents. The facility managed medications for all of the residents and 3 residents received insulin by an insulin pen prepared by staff. Based on interview and record review the administrator failed to ensure staff administered medications in accordance with the manufacturer's recommendations regarding "Priming" of the insulin pens before dialing the prescribed dose. The sample included 1 resident who received insulin (# 948) and staff failed to document the administration of PRN (as needed) sliding scale insulin per standard of practice for resident #948. Findings included: - On 05-11-21 licensed nurse/administrator E provided the resident roster which identified	S3200		

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facility management of medications for all residents. The roster indicated 3 residents received insulin injections.

In the entrance meeting on 05-12-21 licensed nurse/administrator E said the certified medication aides (CMAs) would prepare and dial the insulin pens for all 3 residents and then hand the pen to the resident to inject themselves.

Review of the documentation provided for CMA training and competency on insulin pens revealed the following directions:
Remove the pen cap and clean the top with sterilized alcohol
Affix the needle to the pen. Utilize a new needle each time
Prime the pen, by pushing the injection button with your thumb, you should see a few drops of insulin, if no insulin is seen, repeat priming until insulin is seen.
After priming, dial up the right dose according to the medication administration record (MAR).
Confirm the dosage again prior to providing to the resident for injection.

Interview on 05-12-21 at 11:23 AM with CMA G revealed she had already administered the insulin for resident #948. When asked to describe the steps/procedure she used for the insulin pen she verbalized the following steps: She gets the pen out of the cabinet in the resident's room, attaches the needle/cap, dialed the dose and hand it to the resident. After the resident injects it she removes the needle, puts it in the designated container, puts the pen cap back on and returns to the locked cabinet. When asked about cleaning the pen tip with alcohol she replied she cleans it after the injection when she takes the needle off and puts the pen cap back on. When asked about

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priming the pen she said no she had never done that. She didn't think she was trained to do that.

Interview on 05-12-21 at 11:38 AM with CMA H revealed she had already administered the other 2 resident's insulin. When asked to describe the steps/procedures she used for the insulin pen she verbalized the following steps: She checks the MAR, goes to the resident's room, removes the insulin pen from the locked cabinet, removes the pen cap and cleans the tip with an alcohol pad, attaches a new needle, dials the pen to the prescribed dose and hands the pen to the resident for injection. When asked if she dials the pen to 2 units, pushes the plunger to prime the pen before dialing the dose she said no she had not been trained to do that.

During a meeting on 05-17-21 with licensed nurse/administrator E, licensed nurse A and licensed nurse F they confirmed the manufacturer recommended priming the pen before dialing the prescribed dose.

The manufacture of Novolog Flexpen directed to attach a new needle, pull off the paper tab, push and twist the needle on until it is tight and pull off both needle caps. Prime the pen - turn the dose selector to select 2 units, press and hold the dose button and make sure a drop appears. Then turn the dose selector to select the number of units needed. The manufacture defined Priming the pen meant removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection you may get too much or too little insulin.

The manufacture of Lantus, Humalog and Levemir all recommend priming with each dose.

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S3200	Continued From page 21 The administrator failed to ensure staff administered medications in accordance with the manufacturer's recommendations regarding Priming of insulin pens before dialing the prescribed dose. - Record review for resident #948 revealed an admission date of 06-13-2019 with diagnoses of diabetes type 2 and hypertension. The annual functional capacity screen dated 06-24-2020 identified the resident with a deficit in memory recall. He lacked the ability to manage his own medications and treatments. The negotiated service agreement/health service plan dated 06-24-2020 directed staff the resident would self-inject his insulin after the dosage was drawn up by nursing staff per physician's orders. The medical care provider's order revealed an order for Novolog by flex-pen 4 units before breakfast, 6 units before lunch and 7 units before supper as of 05-06-21. He also had a PRN (as needed) order for Novolog following a sliding scale as follows: 200-299 = 1 unit, 300-399 = 2 units, 400-499 = 3 units. Review of the April 10th thru May 9th and May 10th thru May 12th of 2021 medication administration records (MAR) revealed 3 separate entries for each of the scheduled Novolog doses and a separate entry for the Novolog PRN per sliding scale. Both MARs lacked documentation of PRN usage. Review of the resident's blood sugar record revealed the resident had his blood sugar checked 4 times a day. Review between April 10th thru May 12th of	S3200		

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S3200	Continued From page 22 2021 revealed every day the resident had a least 1 blood sugar reading which met the criteria for the PRN NovoLog sliding scale. On 05-13-21 by email, licensed nurse/administrator E explained staff record the PRN sliding scale insulin dose they administered by adding to the scheduled dose and record the total amount in the section for the scheduled Novolog. On 05-17-21 she confirmed the MAR failed to include the directions of the combination of insulin and confirmed the standard of practice was to document the PRN medications in the PRN section and on the back of the MAR. The administrator failed to ensure staff recorded PRN insulin they administered in accordance with the standard of practice for documentation of PRN medications administered for this resident.	S3200		
S3216 SS=E	26-41-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations:	S3216		

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S3216	Continued From page 23 (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41 205 (i) The facility reported a census of 39 residents and the facility managed the medications for all residents. Based on observation, interview and record review the administrator failed to have a system for accountability on controlled substances stored in the medication room for 10 residents (#210, #214 #222, #237, #249, #252, #264, #270, #275 and #278). Findings included: - On 05-11-21 licensed nurse/administrator E provided the resident roster which indicated the facility managed the medications and treatments for all residents. The facility was divided in 2 sections, a memory care unit and an area not for memory care. On 05-11-21 at 2:59 PM Certified medication aide (CMA) J opened the medication room used to store medications for the non-memory care residents. Observation revealed a cabinet with a padlock on it. CMA J said the cabinet held overstock of controlled substances for residents. She opened the cabinet for inspection and reported the controlled medications were not routinely counted at the change of shift like the	S3216		

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S3216	Continued From page 24 ones on the medication cart. In the cabinet were unit dose cards or bottles of a controlled medication which also had the individual control record for the resident attached to it with a rubber band as follows: Resident #210 had 7 cards (30 each) of alprazolam 0.25 milligram (mg) for a total of 210 tablets with dispense dated in February, March and April of 2021. She had 2 cards of Percocet (1 had 2 tablets and the other had 30) both dispensed on 4-21-21. Resident #214 had a card of hydrocodone/apap 7.5mg/325mg with 30 tabs and dispensed on 12-12-2020. He also had a card which had 57 out of 60 tabs dispensed on 12-09-2020. Resident #222 had 2 cards of hydrocodone/apap 5mg/325mg each had 30 tabs with a dispense date of 4-20-21 Resident #237 had a bottle of guaifenesin/codeine dispensed on 1-11-21. In a Ziplock type baggie with a receipt from the pharmacy and no individual control record was a card of hydrocodone/apap 5mg/325mg (30 tabs) dispensed on 04-12-21 Resident #249 had a card of oxycodone 5 mg (30 tabs) dispensed 10-08-2020 and a card with 6 lorazepam dispensed on 01-08-21 Resident #252 had a card of hydrocodone/apap 5mg/325mg (30 tabs) dispensed 04-20-21 Resident #264 had a card of 30 Tramadol 50 mg dispensed on 10-24-2020 Resident #270 had a card of lorazepam 30 tablets dispensed on 12-05-2020 Resident #275 had a card of 60 Tramadol 50 mg dispensed on 04-27-21 Resident #278 had a card of Tramadol dispensed on 03-12-21 of 60 tabs and 3 cards of 30 each (90 total) dispensed on 04-27-21	S3216		

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S3216	Continued From page 25 Interview on 05-11-21 at 3:05 PM with licensed nurse F confirmed the medications were controlled substances, held as overstock rather than in the medications cart and were not routinely counted or quantity verified. She confirmed the facility lacked a system for accountability of those controlled substances stored in the medication room other than having it under double lock. She confirmed the CMAs had both the medication room key and the cabinet key so therefore with no system for accountability a controlled substance diversion could occur without staff's knowledge. The administrator failed to have a system for accountability on controlled substances stored in the medication room for 10 residents (#210, #214 #222, #237, #249, #252, #264, #270, #275 and #278).	S3216		
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: K.A.R. 26-41-206 (e) The facility reported a census of 39 residents. Based on observation interview and record review the administrator failed to ensure facility staff stored all food under safe and sanitary conditions.	S3299		

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S3299	Continued From page 26 This failure had the potential to affect all residents in the facility. Findings included: - During initial tour of the kitchen on 05-11-21 at 2:14 PM observations revealed: In the double door reach-in refrigerator was 2 opened containers of cottage cheese with no date of when opened, a container of sour cream without a date of when opened, an opened container of whipped cream which had changed to a yellow color and had no date of opening on it and a gallon sized plastic Ziploc type bag with what appeared to be cheese slice without any identification of the food item or date. In the deli-style/salad bar refrigeration was a large bag of shredded cheese that was not properly sealed and fell out when of the bag when moved. It also lacked a date of when the bag of cheese was opened. In the pantry; an open bag of marshmallows inside a Ziploc type bag without a date, 2 open bags of chocolate chips which were twisted shut but not secured and had no date of when opened, 2 open bags of powder sugar in Ziploc plastic bags with no date, an open bag of what looked like brown sugar in a plastic Ziploc bag but not identified and had no date, 2 open boxes of corn starch in Ziploc bags (1 not sealed at all), a gallon size plastic Ziploc bag of a brown sugar appearing food item with white flakes (probably cinnamon sugar mix) which had nothing to identify the food item and no date, an open bag of unspecified gelatin within a Ziploc bag and no label or date, an open bag of a brown granular substance in a Ziploc bag which was not identified or dated, a Ziploc bag of loose cereal without identification but looks like corn flakes	S3299		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALDRON PLACE	1700 E 23RD HUTCHINSON, KS 67502

(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
S3299	Continued From page 27 and no date, in a large plastic unsealed Ziploc bag was a package of opened brown sugar and on top of that in the bag was an open package of Italian seasoning mix and on top of that was an open package of buttermilk pancake mix all without a date. Interview on 05-11-21 with dietary manager K and L confirmed the above items were opened, unlabeled, unsealed and not dated when opened. The Focus on Food Safety from the Kansas Department on Agriculture revised October of 2014 directed to store food items in a way which does not harbor insects or rodents (sealed). Must date mark all food items which are prepared on-site, or commercially processed, after the original container is opened and held under refrigeration. Date mark all potentially hazardous (critical temperature foods), Ready-to-eat foods which are held for more than 24 hours. Food can be held for seven days in adequate refrigeration (41 degrees Fahrenheit or less). The day of preparation or day the commercially processed food is opened counts as day one. The administrator failed to ensure facility staff stored all food under safe and sanitary conditions. This failure had the potential to affect all residents in the facility.	S3299		