STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078016	A. BUILDING _____ B. WING _____	02/01/2017

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
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with investigation of complaint #110921 of the above assisted living facility on 1/23/17, 1/24/17, 1/25/17, 1/26/17, 1/30/17, and 2/1/17.	S 000		
S3026 SS=E	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 45 residents. The sample included 4 residents and 3 residents focus review. Based on record review, interview, and observation for 2 (#400 and #300) of 4 residents sampled and 2 (#600 and #500) of 3 focus review residents, the operator failed to ensure residents were not subjected to neglect when the licensed nurse failed to seek immediate medical attention when each resident experienced signs and symptoms of change in health status and/or injury. Findings included: - Record review for resident #400 revealed an admission date of 5/24/14 and diagnoses of vascular dementia, type 2 diabetes mellitus, and	S3026		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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S3026	Continued From Page 1 unspecified cerebrovascular disease. Functional capacity screen dated 5/24/16 indicated resident was independent with transferring; required supervision with toileting and walking with walker; experienced impaired short-term memory, long-term memory, decision making, and memory recall; no impairment with communication or understanding communication by others; and was at risk for falls. Negotiated service agreement/health care service plan dated 5/24/16 documented services of supervision with toileting; use walker at all times for safety; staff to be aware of risk for falls; management of medications and treatments; resident is understandable when communicating and understands others; and licensed nurse monitored and coordinated all services. Nurse's notes contained the following entries by licensed nurse B: 1/16/17 (no time of the entry) Weekend staff report resident extra groggy and very unsteady gait. Licensed nurse (B) assessed resident this morning and no slurred speech, able to stand/walk straight, eating well. No complaints of pain or problems at this time. Will continue to monitor. The entry lacked documentation of resident's vital signs. The record lacked documentation of notification of medical care provider to report observations reported by staff. 1/16/17 3:00 p.m. staff reports resident slurring words. Licensed nurse (B) assessed resident. No slurred speech noted, equal hand grips. Resident denies any problems. Resident asked to stand and walk, steady, fast gait noted. Informed staff to monitor resident closely.	S3026		

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S3026	Continued From Page 2 The entry lacked documentation of resident's vital signs. The record lacked documentation of notification of medical care provider to report observations reported by staff. 1/17/17 (no time entry made) licensed nurse B documented this entry for 1/16/17 at 5:00 p.m. that he/she received call from medication aide (J) to report at 4:55 p.m. when medication aide (J) notified resident of evening meal, he/she observed resident fall in bathroom on buttocks. Vital signs of temperature 97.8 degrees Fahrenheit, pulse 94, respirations 18 and blood pressure 180/90. Medication aide (J) reported resident acted normal, assisted up from floor, and to dining room for evening meal. Medication aide (J) tried to contact resident's family member to report fall and family member arrived at facility at 6:00 p.m. Family member stated he/she would take resident to be evaluated by medical care provider the next day. About 6:30 p.m. with family member present, resident began slurring words and had pronounced facial drooping. Family member took resident to hospital emergency department and resident admitted for observation for stroke-like symptoms. 1/17/17 (no time of entry) hospital called to report resident to be released from hospital. Final diagnosis transient ischemic attack (temporary episode of neurologic dysfunction caused by loss of blood flow), with MRI (magnetic resonance imaging) showing small acute non-hemorrhagic infarct. The record contained documentation by licensed nurse B dated 1/18/17 and faxed to resident's medical care provider to notify that medication aide witnessed resident fall on 1/17/17 and at 6:30 p.m. resident began having slurred speech and	S3026		

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S3026	Continued From Page 3 left facial drooping. Family member took resident to hospital and resident admitted. Resident returned to facility 1/17/17 and follow-up appointment with you 1/23/17. At 3:35 p.m. on 1/25/17, nurse aide K stated he/she went to inform resident of evening meal around 5:00 p.m. on 1/16/17. Nurse aide K stated he/she observed resident walking in bathroom with unsteady gait and resident fell. Nurse aide K observed resident with facial drooping and noted slurred speech. Medication aide (J) notified licensed nurse (B) of fall and elevated blood pressure reading. Family member came to the facility and decided to take resident to hospital emergency department for evaluation. During an interview at 12:30 p.m. on 1/26/17, licensed nurse B stated staff informed him/her on 1/16/17 that resident had been sleepy and did not want to wake up the day before during the 7:00 a.m. to 3:00 p.m. shift. Licensed nurse B stated he/she observed resident complete morning care for self at 8:00 a.m. on 1/16/17 and resident "was perfectly fine." Licensed nurse B stated he/she assessed resident at 3:00 p.m. on 1/16/17 when staff reported resident with facial drooping and slurred speech and resident was fine. Licensed nurse B stated he/she did not call the resident's medical care provider to notify of symptoms reported by staff members. The operator failed to ensure resident #400 was not subjected to neglect when the licensed nurse failed to seek immediate medical attention when the resident experienced signs and symptoms of change in health status as reported by staff members. - Record review for resident #600 revealed an admission date of 10/26/16 with diagnoses of	S3026		

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S3026	Continued From Page 4 Alzheimer's disease, history of closed head injury, and hypertension. Functional capacity screen dated 10/26/16 indicated resident independent with transferring and walking, required supervision with dressing; experienced impaired short-term memory, long-term memory, decision making, and memory recall; and was at risk for falls. The negotiated service agreement/health care service plan dated 10/26/16 documented the licensed nurse monitored and coordinated all services. This negotiated service agreement/health care service plan lacked interventions to address the resident's risk for falls. Record contained a progress note by a medical care provider dated 9/22/16 that recorded resident fell recently when getting out of shower, hit head, sustained a small subdural hematoma (bleeding into the space between the outer layer and middle layers covering the brain), and required hospitalization. The nurse's notes contained the following entries by licensed nurse B: 10/31/16 (no time of entry) Licensed nurse (B) received a call on 10/30/16 at 11:42 p.m. from a medication aide that resident was found on floor with head resting on wall. Staff reported resident moving and responsive but confused. Licensed nurse B instructed medication aide to get resident up and contact resident's durable power of attorney of need to transport resident to the hospital's emergency department. At 12:17 a.m. on 10/31/16, staff member called to inform nurse resident did not seem to be acting right all day and family on way to facility. At 12:40 a.m. on	S3026		

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S3026	Continued From Page 5 10/31/16, staff member called to inform licensed nurse (B) resident "convulsing" and "foaming at the mouth" in seizure-like activity. Advised staff member to call 911 for emergency medical services (EMS) transport to hospital emergency department for evaluation. 10/31/16 at 8:00 a.m. licensed nurse (B) spoke with resident's family member. Family member stated resident was transferred to another hospital and admitted to intensive care for diagnosis of subdural hematoma. During an interview at 1:05 p.m. on 1/26/17, licensed nurse B confirmed he/she did not obtain immediate medical attention for resident until resident began having seizure-like activity The facility's "fall follow-up protocol" of a fall with head strike documented the physician should be notified regardless of the time when a fall involving a head strike occurs. The record lacked documentation of medical care provider notification at the time of the fall. The operator failed to ensure resident #600, who had a history of subdural hematoma from a fall approximately 1 month earlier, was not subjected to neglect when the licensed nurse failed to seek immediate medical attention after the resident fell and struck head. Approximately 1 hour after the fall resident experienced seizure-like activity, was transported to the hospital by emergency medical services and admitted to the intensive care unit with an acute subdural hematoma. - Record review for resident #300 revealed an admission date of 11/7/16 with diagnoses of vascular dementia, osteoporosis, and hypertension.	S3026		

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S3026	Continued From Page 6 Functional capacity screen dated 11/7/16 indicated resident was independent with transferring, walking, and toileting and experienced impaired short-term memory, long-term memory, decision making and memory recall. Negotiated service agreement/health care service plan dated 11/7/16 recorded the service of licensed nurse monitored and coordinated all services. The nurse's notes contained the following entries by licensed nurse B: 12/12/16 "late entry" received call on 12/11/16 at 12:32 p.m. from medication aide to report resident had fallen and was found lying on back in hallway. Resident denied pain and licensed nurse (B) instructed medication aide to get resident up and into a chair. Medication aide called licensed nurse (B) again and reported after sitting resident in chair the resident became pale and complained of being nauseated and dizzy. Then resident stopped responding to staff member's questions. Instructed staff to call resident's family member immediately and ask them if they would like to take resident to emergency department or if they wanted 911 called for transport. Staff member reports after contacting family member resident became responsive. Family member arrived at facility and refused evaluation of resident at the hospital. The record lacked an assessment of the resident by the licensed nurse. On 12/13/16, licensed nurse B sent a fax to the resident's medical care provider to notify of the fall that occurred on 12/11/16. 12/26/16 (no time of entry) received call approximately 3:00 p.m. of staff reporting bruising and swelling to right foot and ankle. Staff	S3026		

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S3026	Continued From Page 7 instructed to call family member to take to be seen by medical care provider the next day. Note: no care instructions to staff members documented. 12/27/16 nurse documented he/she assessed resident at 7:30 a.m. and family member taking to medical care provider for evaluation. Resident to be non-weight bearing and medical care provider aware of difficulty of this due to dementia. Record contained a medical care provider note dated 12/28/16 with documentation of Lisfranc fracture right foot involving the 2nd, 3rd, and 4th metatarsal bases (injury of foot with one or more metatarsal bones displaced from the tarsus). Resident's right lower leg and foot placed in a cast and order for resident to be non-weight bearing. At 2:57 p.m. on 1/23/17, observed resident sitting at table in dining room area. A certified staff member came to resident to inform of phone call in resident's room. Resident got up from chair and walked to room with certified staff member pushing wheelchair behind resident. Observed cast present to right lower leg/foot. The record lacked documentation to indicate resident could now walk and bear weight on right foot. At 4:37 p.m. on 1/25/16, licensed nurse B stated first aware of injury to foot maybe on Sunday evening (12/25/16) and did not contact resident's medical care provider when he/she became aware of injury because family member planned to take resident to medical care provider the next day. The operator failed to ensure resident #300 was not subjected to neglect when the licensed nurse failed to seek immediate medical attention for resident when staff members observed resident	S3026		

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S3026	Continued From Page 8 limping, right foot and ankle bruised and swollen, and resident complained of pain. - Record review for resident #500 revealed an admission date of 8/19/16 with diagnoses of mild cognitive impairment and diabetes mellitus. Functional capacity screen dated 8/19/16 indicated resident was independent with transferring and walking and experienced impaired short-term memory, long-term memory, decision making, and memory recall. The functional capacity screen did not indicate resident was at risk for falls. Negotiated service agreement/health care service plan dated 8/19/16 recorded the service of licensed nurse monitored and coordinated all services. The nurse's notes contained the following entry by licensed nurse B: 1/18/17 (no time of entry) Medication aide contacted this nurse to report he/she heard someone yelling for help at 8:25 p.m. (no date documented) and found resident on floor in room. Resident complained of pain to left shoulder and resident had a large bruise/hematoma to left brow/eye area. Resident assisted up from floor. Medication aide denied resident with cognitive issues, eyes able to track and no broken vessels in eye. Staff instructed to begin fall follow-up with head strike immediately and notify resident's durable power of attorney of fall. Durable power of attorney contacted this nurse by phone and asked if resident should go to emergency department. Licensed nurse B documented he/she informed durable power of attorney that an emergency department visit did not seem	S3026		

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S3026	Continued From Page 9 necessary at this point but that it was up to durable power of attorney to decide. Durable power of attorney requested to be informed of any changes or decline noted in resident. The facility's "fall follow-up protocol" of a fall with head strike documented the physician should be notified regardless of the time when a fall involving a head strike occurs and "we should always encourage ER (emergency room) evaluation to rule out head injury." The record lacked documentation of medical care provider notification at the time of the fall or in the days thereafter. The record lacked a follow-up assessment by a licensed nurse. On 1/23/17 at 11:50 a.m. in the memory care dining room, observed resident #500 sitting at a table. Observed large bruise surrounding left eye. Nurse aide L stated resident's injury caused by a fall. At 4:20 p.m. on 1/25/17, licensed nurse B stated he/she did not come to facility to assess resident after the incident because resident's vital signs were not abnormal. Licensed nurse B confirmed he/she did not seek medical attention for resident. The operator failed to ensure resident #500 was not subjected to neglect when the licensed nurse failed to assess resident and seek medical attention for resident who fell, struck head and complained of shoulder pain.	S3026		
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	S3155		

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S3155	Continued From Page 10 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 45 residents. The sample included 4 residents and 3 residents focus review. Based on record review, interview, and observation for 2 (#600 and #500) of 3 focus review residents and 1 (#400) of 4 residents sampled, the operator failed to ensure a licensed nurse provided and/or coordinated the provisions of necessary health care services for these residents at risk for falls. Findings included: - Record review for resident #600 revealed an admission date of 10/26/16 with diagnoses of Alzheimer's disease, history of closed head injury, and hypertension. Functional capacity screen dated 10/26/16 indicated resident independent with transferring and walking, required supervision with dressing; experienced impaired short-term memory, long-term memory, decision making, and memory recall; and was at risk for falls. The negotiated service agreement/health care service plan dated 10/26/16 documented the licensed nurse monitored and coordinated all services. This negotiated service agreement/health care service plan lacked interventions to address the resident's risk for falls.	S3155		

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S3155	Continued From Page 11 Record contained a progress note by a medical care provider dated 9/22/16 that recorded resident fell recently when getting out of shower, hit head, sustained a small subdural hematoma (bleeding into the space between the outer layer and middle layers covering the brain), and required hospitalization. The nurse's notes contained the following entries by licensed nurse B: 10/31/16 (no time of entry) Licensed nurse (B) received a call on 10/30/16 at 11:42 p.m. from a medication aide that resident was found on floor with head resting on wall. Staff reported resident moving and responsive but confused. Licensed nurse B instructed medication aide to get resident up and contact resident's durable power of attorney of need to transport resident to the hospital's emergency department. At 12:17 a.m. on 10/31/16, staff member called to inform nurse resident did not seem to be acting right all day and family on way to facility. At 12:40 a.m. on 10/31/16, staff member called to inform licensed nurse (B) resident "convulsing" and "foaming at the mouth" in seizure-like activity. Advised staff member to call 911 for emergency medical services (EMS) transport to hospital emergency department for evaluation. 10/31/16 at 8:00 a.m. licensed nurse (B) spoke with resident's family member. Family member stated resident was transferred to another hospital and admitted to intensive care for diagnosis of subdural hematoma. 11/18/16 resident readmitted to facility. The negotiated service agreement/health care service plan lacked revision when resident	S3155		

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S3155	Continued From Page 12 returned to facility to address resident's risk for falls. At 3:22 p.m. on 1/25/17, medication aide F stated he/she made sure room well-lit and free of clutter as interventions to address resident's risk for falls. Medication aide F stated resident refused to allow staff to assist with dressing. At 1:05 p.m. on 1/26/17, licensed nurse B confirmed the negotiated service agreement/health care service plan lacked interventions to address resident's risk for falls at the time of admission to the facility. Licensed nurse B confirmed he/she did not revise the negotiated service agreement/health care service plan to address resident's risk for falls when resident returned to facility from hospital and rehabilitation stay. The operator failed to ensure a licensed nurse provided and/or coordinated the provisions of necessary health care services for resident #600. - Record review for resident #500 revealed an admission date of 8/19/16 with diagnoses of mild cognitive impairment and diabetes mellitus. Functional capacity screen dated 8/19/16 indicated resident was independent with transferring and walking and experienced impaired short-term memory, long-term memory, decision making, and memory recall. The functional capacity screen did not indicate resident was at risk for falls. Negotiated service agreement/health care service plan dated 8/19/16 recorded the service of licensed nurse monitored and coordinated all services.	S3155		

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S3155	Continued From Page 13 The nurse's notes contained the following entry by licensed nurse B: 1/18/17 (no time of entry) Medication aide contacted this nurse to report he/she heard someone yelling for help at 8:25 p.m. (no date documented) and found resident on floor in room. Resident complained of pain to left shoulder and resident had a large bruise/hematoma to left brow/eye area. Resident assisted up from floor. Medication aide denied resident with cognitive issues, eyes able to track and no broken vessels in eye. Staff instructed to begin fall follow-up with head strike immediately and notify resident's durable power of attorney of fall. Durable power of attorney contacted this nurse by phone and asked if resident should go to emergency department. Licensed nurse B documented he/she informed durable power of attorney that an emergency department visit did not seem necessary at this point but that it was up to durable power of attorney to decide. Durable power of attorney requested to be informed of any changes or decline noted in resident. On 1/23/17 at 11:50 a.m. in the memory care dining room, observed resident #500 sitting at a table. Observed large bruise surrounding left eye. Nurse aide L stated resident's injury caused by a fall. The negotiated service agreement/health care service plan lacked revision to include interventions to address the resident's risk for falls. At 3:10 p.m. on 1/25/17, medication aide F stated to reduce resident's risk for falls he/she reminded resident to ambulate with walker and offered to assist resident with toileting and dressing.	S3155		

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S3155	Continued From Page 14 The operator failed to ensure a licensed nurse provided and/or coordinated the provisions of necessary health care services for resident #500. - Record review for resident #400 revealed an admission date of 5/24/14 and diagnoses of vascular dementia, type 2 diabetes mellitus, and unspecified cerebrovascular disease. Functional capacity screen dated 5/24/16 indicated resident was independent with transferring; required supervision with toileting and walking with walker; experienced impaired short-term memory, long-term memory, decision making, and memory recall; and was at risk for falls. Negotiated service agreement/health care service plan dated 5/24/16 documented licensed nurse monitored and coordinated all services. The negotiated service agreement/health care service plan documented staff to be aware resident at risk for falls but lacked interventions to reduce resident's risk for falls. Nurse's notes contained the following entries by licensed nurse B documenting resident falls: 7/12/16 (no time on entry) medication aide heard resident call for help and found resident on bathroom floor. Requested order for occupational and physical therapy. 8/22/16 (no time on entry) received call from medication aide at 5:00 p.m. on 8/20/16 reporting resident found on bathroom floor. (No date on entry) Late entry for 11/24/16 medication aide called nurse at 6:30 a.m. to report	S3155		

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S3155	Continued From Page 15 resident on floor of room. Resident stated fell when getting up from bed. Complained of left hip pain. At 8:45 p.m. medication aide called to report resident fell when ambulating without walker. 1/17/17 (no time entry made) licensed nurse B documented this entry for 1/16/17 at 5:00 p.m. that he/she received call from medication aide (J) to report at 4:55 p.m. when medication aide (J) notified resident of evening meal, he/she observed resident fall in bathroom on buttocks. Vital signs of temperature 97.8 degrees Fahrenheit, pulse 94, respirations 18 and blood pressure 180/90. Medication aide (J) reported resident acted normal, assisted up from floor, and to dining room for evening meal. Medication aide (J) tried to contact resident's family member to report fall and family member arrived at facility at 6:00 p.m. Family member stated he/she would take resident to be evaluated by medical care provider the next day. About 6:30 p.m. with family member present, resident began slurring words and had pronounced facial drooping. Family member took resident to hospital emergency department and resident admitted for observation for stroke-like symptoms. 1/17/17 resident returned to facility at 4:45 p.m. and to be on 30 minute checks for 1 week. 1/20/17 resident slid out of bed at 9:30 a.m. 1/21/17 medication aide called to report resident had been checked on 5 minutes prior and then at 10:05 a.m. found resident on floor. Resident stated was getting up to go to bathroom, lost balance, and fell. During an interview at 3:27 p.m. on 1/25/17, medication aide F stated try to keep resident in living area or if resident in room then leave door	S3155		

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S3155	Continued From Page 16 open in order to visually monitor resident. Medication aide F stated he/she assisted resident with toileting and stand-by assistance with transferring and walking. Negotiated service agreement/health care service plan lacked revision to address resident's risk for falls. The operator failed to ensure a licensed nurse provided and/or coordinated the provisions of necessary health care services for resident #400.	S3155		
S3166 SS=E	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This Requirement is not met as evidenced by: KAR 26-41-204(e) The facility reported a census of 45 residents. The sample included 4 residents and 3 focus review residents. Based on record review and interview for 1 (#500) of 1 focus review residents requiring blood glucose monitoring and 2 of 2 certified medication aide files reviewed, the licensed nurse failed to document each medication aide's competency to perform blood glucose monitoring with a glucometer in each medication aide's employee file. Findings included:	S3166		

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S3166	Continued From Page 17 - Record review for resident #500 revealed an admission date of 8/19/16 and diagnosis of diabetes mellitus. Negotiated service agreement/health care service plan recorded blood glucose testing two times a day. Review of employee files on 1/27/17 revealed medication aide F hired 6/9/16 and medication aide G hired 10/14/16. At 11:40 a.m. licensed nurse B stated each medication aide worked in the memory care building and he/she instructed each aide to perform blood glucose monitoring of resident with a glucometer. The employee files lacked documentation of delegation of the procedure. Licensed nurse B stated he/she did not document the delegation of the nursing procedure in each aide's personnel file. The licensed nurse failed to document each medication aide's competency to perform blood glucose monitoring with a glucometer in each medication aide's employee file.	S3166		
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This Requirement is not met as evidenced by: KAR26-41-204(i) The facility reported a census of 45 residents. The sample included 4 residents and 3 residents focus review. Based on record review and interview for 2 (#200 and #300) of 4 residents sampled, the operator failed to ensure health care service of medication management was provided	S3171		

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S3171	Continued From Page 18 to residents by qualified staff in accordance with acceptable standards. Findings included: - Record review for resident #200 revealed an admission date of 8/3/15 and diagnosis of hypertension. Functional capacity screen dated 8/15/16 indicated resident was unable to perform management of medications. Negotiated service agreement/health care service plan dated 8/15/16 recorded medication management by nursing staff. Review of the 1/10/17 through 2/8/17 medication administration record revealed an entry of meclizine 12.5 milligrams 1/2 to 1 tablet by mouth every 8 hours as needed. The entry lacked the reason for the medication. A medication aide initialed the medication administration record 1/21/17 to indicate the resident received the medication. At 1:20 p.m. on 1/25/17, licensed nurse H provided documentation on the back of the medication administration record by a medication aide that resident received 1 tablet of meclizine on 1/21//17 for complaint of dizziness. Licensed nurse H stated certified medication aides did not call nurse prior to administering medications ordered on an as needed basis. Licensed nurse H confirmed he/she was not contacted of resident's complaints and/or symptoms in order to assess resident and direct the medication aide. - Record review for resident #300 revealed an admission date of 11/7/16 and diagnoses of vascular dementia and osteoporosis. Functional capacity screen dated 11/7/16 indicated resident was unable to perform management of medications. Negotiated service agreement/health care service plan dated 11/7/16 recorded the service of medication management	S3171		

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S3171	Continued From Page 19 by staff. Review of the nurse's notes revealed an entry by licensed nurse B on 12/26/16 that a staff member called nurse to report resident's right foot and ankle bruised and swollen. The resident record lacked documentation of the cause of the injury. Interview at 3:30 p.m. on 1/24/17 with medication aide F who stated resident complained of pain in foot on 12/25/16 and medication aide noticed resident limping and he/she gave resident Tylenol for pain relief. Medication aide F stated he/she did not call licensed nurse prior to administering Tylenol for pain relief. At 4:37 p.m. on 1/24/17, licensed nurse B stated medication aides administered medications on an as needed basis without calling the licensed nurse. The operator failed to ensure health care service of medication management was provided to residents by qualified staff in accordance with acceptable standards.	S3171		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in	S3215		

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S3215	Continued From Page 20 separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This Requirement is not met as evidenced by: KAR 28-41-205(h) The facility reported a census of 45 residents. The sample included 4 residents and 3 focus review residents. Based on observation and interview the medication aide failed to ensure all medications were stored in a locked medication room, cabinet, or medication cart. Findings included: - At 12:00 p.m. on 1/23/17 with the operator, observed a medication cart sitting in the hall outside the door to the dining room. Opened the cart and observed a bottle of Pepto-Bismol. Opened a drawer and observed 3 plastic medication cups. One cup held 1 medication tablet, another cup held 2 medication tablets, and	S3215		

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S3215	Continued From Page 21 the third held 5 medication tablets. The containers were not labeled to indicate the contents of the cups or the name of the resident to receive the medications. The operator summoned medication aide E from the dining room to come to the medication cart. Medication aide E stated he/she had removed these medications from the medication storage cabinet in each resident's room and placed the medications in the medication cart. Medication E stated this medication cart would not lock and confirmed medications were left unlocked and unattended. The medication aide failed to ensure all medications were stored in a locked medication room, cabinet, or medication cart.	S3215		
S3420 SS=F	28-39-256 MECHANICAL REQUIREMENTS (c) Mechanical requirements. (1) Heating, air conditioning, and ventilating systems. (A) The system shall be designed to maintain a year-round indoor temperature range of 70oF or 21oC to 85oF or 26oC. (B) Each apartment or individual living unit shall allow the resident to control the temperature. (2) Plumbing and piping systems. (A) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (B) Water distribution systems shall be arranged to provide hot water at outlets at all	S3420		

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S3420	Continued From Page 22 times. The temperature of hot water shall range between 98oF and 120oF at bathing facilities, sinks, and lavatories in resident use areas. (3) Electrical requirements. (A) All spaces occupied by persons or machinery and equipment within the buildings, approaches to buildings, and parking lots shall have adequate lighting. (B) Minimum lighting intensity levels shall be as required in Table 1. (C) Each corridor and stairway shall remain lighted at all times. (D) Each light in resident use areas shall be equipped with shades, globes, grids, or glass panels. This Requirement is not met as evidenced by: KAR 28-39-256(c)(2)(B) The facility reported a census of 45 residents. The sample included 4 residents and 3 focus review residents. Based on observation, record review, and interview for all residents, the operator failed to implement a system to ensure a hot water temperature range between 98 degrees Fahrenheit (F) and 120 degrees F at bathing facilities, sinks, and lavatories in resident use areas. Findings included: - At 1:18 p.m. on 1/23/17, obtained a hot water temperature reading of 144.5 degrees F from the sink in the spa room of the memory care building. Observed a toilet, shower, and whirlpool also in this room. Licensed nurse C stated this room	S3420		

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S3420	Continued From Page 23 remained locked when not in use by a resident with a staff member present. At 1:20 p.m. on 1/23/17 in the memory care building with licensed nurse B present began checking hot water temperature in 14 occupied resident rooms at the bathroom sink. Hot water temperatures ranged from 109 degrees F to 116.2 degrees F. At 1:30 p.m. on 1/23/17, the maintenance director stated he/she did not routinely measure hot water temperatures from the sink and shower in resident rooms. Maintenance director stated he/she recorded the thermometer reading daily from the large hot water tank that supplied resident use areas and the small tank that supplied the kitchen. Observed the large hot water tank with a digital setting of 115 degrees F and a smaller hot water tank. Maintenance director C read the large tank thermometer gauge as 115 degrees F and the small tank thermometer gauge at 150 degrees F. Returned to spa room and obtained hot water temperature reading of 73.5 degrees from the sink, 105.8 degrees F from the whirlpool, and hot water temperature reading fluctuated between 92 and 114 degrees F from the shower. Licensed nurse B posted a sign on the spa room door to not use the spa room. At 2:00 p.m. on 1/23/17, reviewed December 2016 documentation by maintenance director C that recorded large hot water tank thermometer reading of 115 degrees F and the small hot water tank at 150 degrees F. The records lacked documentation of hot water temperature readings in resident rooms. On 1/23/17 in the assisted living building, obtained hot water temperature reading of 120.5 degrees F from the sink in the public bathroom and 118.2	S3420		

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S3420	Continued From Page 24 degrees F from the sink in the cafe. On 1/24/17 in the assisted living building room of sampled resident #100, obtained a hot water temperature reading of 120 degrees F from the kitchen sink and 119.8 degree F from the sink in the bathroom. On 1/25/17, in the assisted living building room of sampled resident #200, obtained a hot water temperature reading of 123 degrees F from the bathroom sink and 123.8 degrees F from the kitchen sink. During an interview at 4:00 p.m. on 1/23/17, operator D stated a plumber had been contacted to determine the cause of the out of range hot water temperature in the spa room in the memory care building. Operator D informed of lack of monitoring of hot water temperatures at outlets accessible to residents. At 1:45 p.m. on 1/24/17, maintenance director C stated plumber determined the sink in the spa room was supplied by the same hot water tank that was set at 150 degrees F but shower and whirlpool in spa room were supplied by hot water tank set at 115 degrees F. Maintenance director C stated plumber to install a mixing valve to the sink. During an interview at 1:07 p.m. on 1/25/17, maintenance director C stated he/she monitored the thermometer gauges on hot water tanks in the assisted living building and if in range he/she would check hot water temperature in 2 resident rooms. Maintenance director C stated he/she did not record the hot water temperature readings. The operator failed to implement a system to ensure a hot water temperature range between 98 degrees F and 120 degrees F at bathing facilities, sinks, and lavatories in resident use areas.	S3420		

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If deficiencies are cited, an approved plan of correction is requisite to continued program participation.