STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N085014	A. BUILDING: _____ B. WING _____	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF SALINA	2605 S OHIO STREET SALINA, KS 67401

(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 an initial survey with a complaint (#189500) at the above named facility conducted on 07/29/24.	S 000		
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: KAR 26-41-204 (i) The facility reported a census of 48 residents with three included in the sample. Based on observation, interview and record review, Operator A failed to ensure a licensed nurse completed an assessment for the purpose to use a bed assist device and ability to use a bed assist safely for Resident (R)1. Operator A further failed to ensure qualified staff provided healthcare services in accordance with acceptable standards of practice when facility staff failed to respond to call lights in a timely manner. Findings included: - Record review for R1 revealed an admission date of 01/30/24 with diagnoses of hemiplegia and epilepsy. The 01/17/24 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with bathing, toileting, transferring, and mobility, was unable to perform transfers and was marked as	S3171		

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

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S3171	Continued From page 1 risk for falls/ unsteadiness. The 01/17/24 "Negotiated Service Agreement" (NSA)/ Health Care Service Plan instructed facility staff to provide the following health services: two-person assistance with bathing, dressing, and transferring. The NSA further identified R1 required assist of two people to transfer in and out of bed and chairs at all times. R1's record lacked evidence of documentation of a bed assist device assessment. Record review of the July 2024 facility call light log dated 07/26/24 including all lights dated 07/29/24 revealed R1 pressed her pendant call light at 05:51:44 AM and the response time was 23 minutes and 9 seconds. Review of the July 2024 call light report for R1 dated 07/26/24 revealed four call light response times greater than 15 minutes, three of which were over 20 minutes. Observation on 07/29/24 at 04:10 PM revealed a transfer pole was installed to the right side of R1's chair and to the right side of her bed. Interview of R1 on 07/29/24 at 04:10 PM revealed the R1 had concern of the call light response time being "upwards of 20 minutes." On 07/29/24 at approximately 04:13 PM, R1 stated she used the transfer pole to help her get and in and out of the chair. She also stated she had a transfer pole in her bedroom. Interview on 07/29/24 at approximately 04:28 PM Administrative Nurse B confirmed R1's record lacked evidence of documentation of a bed assist device assessment.	S3171		

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S3171	Continued From page 2 - Record review for R2 revealed an admission date of 06/03/24 with diagnoses of type 2 diabetes mellitus, hypertension, hyperlipidemia and hypocalcemia. The 07/26/24 FCS recorded R2 required supervision with bathing and physical assistance with toileting and management of medications and treatments. The 07/06/24 NSA/ Health Care Service Plan instructed facility staff to provide the following health services: reminders and assistance for bathing, assistance with toileting and performance of safety checks. Review of the July 2024 call light report log for R2 dated 07/26/24 revealed two call light response times greater than 15 minutes, one of which was over 20 minutes. Review of the call light report log for R2 dated 07/27/24 revealed two call light response times greater than 10 minutes. Observation on 07/29/24 at 01:53 PM revealed R2 pressed his call light with his pendant. At 02:02 PM the call light had not been answered by facility staff. Interview on 07/29/24 at 01:34 PM with R2 revealed the resident had concern of the call light response time being approximately "5-8 minutes." Interview on 07/29/24 at approximately 04:28 PM Administrative Nurse B states that all staff cover all the residents so call lights should still be answered appropriately during report. Facility's "Use of Pagers and Walkie Talkies Policy and Procedures" (no date) recorded, "3.	S3171		

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S3171	Continued From page 3 When an employee's pager is alerted, they should immediately respond. While all pages should be responded to as soon as safely possible, door and window alarms require immediate attention. 4. If an employee is unable to immediately respond to a page, he/she should use a walkie talkie to ask for assistance. If assistance is not available, the employee should leave the resident they are currently a assisting in a safe environment to respond to the other page. If the page is not urgent, you may go back to the original resident to finish assisting them." Operator A failed to ensure a licensed nurse completed an assessment for the purpose to use a bed assist device and ability to use a bed assist safely for Resident (R)1. Operator A further failed to ensure qualified staff provided healthcare services in accordance with acceptable standards of practice when facility staff failed to respond to call lights in a timely manner.	S3171		
S3175 SS=D	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 4	S3175		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-205 (a) (1)

The census equaled 48 residents. The sample included 3 residents. Based on record review, interview and observation for 1 sampled Resident (R)2, the facility failed to ensure a licensed nurse (LN) performed an assessment for residents who self-administered some or all of their medications.

Findings included:

- The "Resident Roster" obtained on 07/29/24 from Operator A identified five residents as self-administering medications and identified two residents as requiring insulin by injection.

- Record review for R2 revealed an admission date of 06/03/24 with diagnosis of type 2 diabetes mellitus.

Review of resident's current "Functional Capacity Screen" dated 07/26/24 recorded the resident required physical assistance with management of medications and treatments.

Review of resident's current "Negotiated Service Agreement" / Health Care Service Plan dated 07/06/24 recorded facility staff assisted R2 with all aspects of medication management but failed to specify insulin administration.

Review of R2's record lacked evidence a licensed

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S3175	Continued From page 5 nurse performed a self-administration of medication assessment. Observation and interview on 07/29/24 at 01:35 PM in R2's room revealed Certified Medication Aide (CMA) D hand R2's prefilled insulin syringe and R2 self-injected the insulin in his abdomen. Review of R2's July 2024 "Medication Administration Record" (MAR) revealed the following, "Fiasp 100 units, inject 5 units subcutaneously three times daily" signed off as administered by certified staff three times daily, starting on 07/24/24 at 08:00 PM through 07/29/24, "Basaglar 100 units, inject 32 units subcutaneously once daily at bedtime" signed off by certified staff from 07/24/24 through 07/28/24. Interview on 07/22/24 at 03:28 PM with Licensed Nurse (LN) B confirmed record lacked a self-administration assessment for R2 to self-inject his insulin. The facility failed to ensure a licensed nurse performed an assessment for R2, who self-injected his insulin.	S3175		
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 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	S3211		

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S3211	Continued From page 6	S3211		

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 30 residents in the assisted living and 18 in the memory care. Based on observation and interview, Operator A 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 in the assisted living and one OTC in the memory care.

Findings included:

- Observation on 07/29/24 at 11:37 AM revealed the assisted living medication cart contained the following OTC medications were not labeled with residents' full names:

One bottle of multivitamin (dietary supplement) for Resident (R)7,
One bottle glucosamine chondroitin (dietary supplement) for R8
One bottle of Aspirin (non-steroidal anti-inflammatory drug) 81 milligrams for R9,
One bottle of Vitamin D3 (dietary supplement) for R10,
One bottle of Miralax (laxative) for R11.

On 07/29/24 at approximately 11:40 AM "Certified Medication Aide" (CMA) D confirmed five OTC

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S3211	Continued From page 7 medications in the assisted living medication cart were not labeled with residents' full names. - Observation on 07/29/24 at 12:06 PM revealed the memory care medication cart contained the following OTC medication, which was not labeled with the resident's full name: One bottle of folic acid (dietary supplement) for R13. On 02/07/24 at approximately 12:08 PM CMA E confirmed one OTC medications in the memory care medication cart was not labeled with resident's full name. Facility's "Medication eMAR to Cart Audit Policy and Procedures" dated 01/22 recorded, "OTC medications and sample medications have the resident's name and open date." Operator A failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of six OTC medications.	S3211		
S3213 SS=D	26-41-205 (g) (2) Medication Labeling (g) (2) Each prescription medication container shall have a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14. This REQUIREMENT is not met as evidenced by:	S3213		

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S3213	Continued From page 8 KAR 26-41-205 (g) (2) The facility reported a census of 48 residents. Based on observation, interview and record review, Operator A failed to ensure prescription medication containers were labeled with a prescription label provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14 for 1 sampled resident (R)2 and 1 non-sampled resident (R)12. Findings included: - Observation on 07/29/24 at 11:46 AM with Certified Medication Aide (CMA) D of the medication cart revealed two insulin injector pens, which were not labeled with resident's name. CMA D identified the two insulin injector pens as belonging to R2 and R12. One of the injector pens had a manufacture label of Tresiba FlexTouch Pen and the other had a manufacture label of Basaglar KwikPen. Neither injector pens had any other identification or pharmacist labeling. Review of R2's July 2024 "Medication Administration Record" (MAR) revealed the following, "Basaglar 100 units, inject 32 units subcutaneously once daily at bedtime" signed off as administered by certified staff from 07/24/24 through 07/28/24. Signed physician orders dated 07/22/24 for R2 recorded, "Basaglar 100 units/ milliliter, inject 32 units subcutaneously once a day (at bedtime) for diabetes." Review of R12's current July 2024 MAR revealed the following, "Tresiba Flex Injection 200 units,	S3213		

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S3213	Continued From page 9 inject 60 units subcutaneously one time daily." Signed physician orders dated 06/24/24 for R12 recorded, "Tresiba Flex Injection 200 units, inject 60 units subcutaneously one time daily." Interview on 07/29/24 at 11:46 AM with CMA D confirmed neither insulin injector pens were labeled. Facility's "Medication eMAR to Cart Audit Policy and Procedures" dated 01/22 recorded, "Medications should be available, current, and appropriately labeled ... Multi-use medications such as insulin ...should be dated when opened." Operator A failed to ensure prescription medication containers were labeled with a prescription label provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14 for 1 sampled resident (R)2 and 1 non-sampled resident (R)12.	S3213		
S3215 SS=F	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 10	S3215		

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 26-41-205(h)(1)(4)

The facility reported a census of 48 residents. Based on observation, interview, and record review, Operator A failed to ensure staff stored Tuberculin solution properly to ensure it was not accidentally administered beyond the manufacturers recommended date of expiration, which had the potential to affect all residents.

- On 07/29/24 at 11:26 AM Licensed Nurse (LN) B revealed a medication refrigerator inside the locked medication room in the facility. The medication refrigerator contained a box with an opened vial of Tuberculin solution. The Tuberculin solution did not include an open date.

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S3215	Continued From page 11 On 07/29/24 at 11:26 AM, LN B confirmed there was not an open date on the vial. Tuberculin manufacturer guidelines directions for storage include to date the tuberculin vial when opening and discard it after 30 days. Operator A failed to ensure staff stored the tuberculin solution, so it was not accidentally administered beyond the manufacturers or pharmacy' recommended date of expiration, which had the potential to affect all residents.	S3215		
S3280 SS=E	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: (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:	S3280		

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S3280	Continued From page 12 KAR 26-41-104 (d) (3) (4) The census equaled 48 residents including 30 assisted living and 18 memory care residents.. The sample included 3 residents. Based on record review and interview, Operator A failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's entire "Emergency Management Plan" with residents and staff and an annual emergency drill with staff and memory care residents to include an evacuation of the residents to a secure location. Findings included: - Review of the facility "Emergency Management Plan" revealed the plan contained procedures to manage potential emergencies and disasters including fire, flood, severe weather, tornado, explosion, natural gas leak, lack of electrical or water service, and missing residents. Facility failed to provide quarterly reviews of the emergency management plan with memory care unit residents for the first and second quarters of 2024. Review on 07/29/24 of the facility's quarterly reviews of the emergency management plan with assisted living residents revealed the following reviews with residents: On 02/28/24, the facility reviewed natural gas leak, On 03/22/24, the facility reviewed severe weather, On 04/19/24, the facility reviewed loss of electrical and water services On 05/31/23, the facility reviewed severe	S3280		

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S3280	Continued From page 13 weather, On 06/21/24, the facility reviewed fire, On 07/19/24, the facility reviewed tornado. The facility failed to review the procedures to manage potential emergencies including fire, flood, tornado, loss of electrical and water services, explosion and missing resident for the first quarter of 2024 with assisted living residents. The facility failed to review the procedures to manage potential emergencies including flood, tornado, natural gas leak, explosion and missing resident for the second quarter of 2024. Facility failed to perform an annual emergency drill conducted with memory care unit residents and the minimum number of staff on duty at one time that included an evacuation of all residents to a secure location. Interview on 07/29/24 at 04:29 PM with Staff G confirmed the facility's records lacked documentation all eight emergency topics were reviewed each quarter with assisted living residents and further confirmed quarterly reviews were not completed with memory care unit residents. Operator A failed to ensure disaster and emergency preparedness by the failure to ensure the performance of quarterly reviews of the facility's entire "Emergency Management Plan" with all residents and an annual emergency drill conducted with staff and memory care residents to include an evacuation of the residents to a secure location.	S3280		

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S3299	Continued From page 14	S3299		
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 48 residents. The facility had a main kitchen where food was stored and prepared for all residents. Based on observation and interview, Operator A failed to ensure food items were stored under safe and sanitary conditions. Findings included: - Observation on 07/29/24 at 10:45 AM in the kitchen revealed two "reach in" refrigerators and a walk-in refrigerator that contained food items for the residents. There were no temperature logs for either reach-in refrigerator. Both refrigerators found to have thermometers located on them. Reach-in refrigerator #1 contained the following food items that lacked a date the food was opened: One bottle of strawberry syrup, One bottle of chocolate syrup, One bottle of ketchup. On 07/29/24 at approximately 10:48 AM Dietary	S3299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N085014	A. BUILDING: _____ B. WING _____	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF SALINA	2605 S OHIO STREET SALINA, KS 67401

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S3299	Continued From page 15	S3299		

Staff F confirmed the food items lacked a date the food was opened.

The walk-in refrigerator contained the following food items that were unsealed:

One box of sausage patties,
One plastic wrapped package of squash.

On 07/29/24 at approximately 10:50 AM Dietary Staff F confirmed the food items were unsealed. Dietary staff F confirms the food items should be wrapped and/or sealed.

Observation on 07/29/24 at 10:52 AM in reach in refrigerator space #2 contained the following food items that were undated and unsealed.

One Ziploc bag of tortillas,
One package containing whipped topping,
One package containing sausage patties.

On 07/29/24 at approximately 10:52 AM Dietary Staff F confirmed the food items were undated and unsealed.

The Kansas Department of Agriculture's "Focus on Food Safety" booklet Page 19 explains that cold foods in storage must be date marked appropriately and to cover foods to maintain cold holding temperature. Page 20 explains that commercially prepared foods must be date marked after the original container was opened and held under refrigeration.

Facility's "Food Storage Policy and Procedures" (no date) recorded, "1.) Food Service Director will lead training for all kitchen employees on the proper storage and labeling of foods, opened and unopened. 2.) Food Service Director will inspect

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S3299	Continued From page 16 and ensure that all opened foods are properly dated and stored daily. This will include inspecting damaged boxes to look for opened bags." Operator A failed to ensure foods were stored under safe and sanitary conditions.	S3299		