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	N087053	A. BUILDING: _____ B. WING _____	10/20/2022

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S 000	INITIAL COMMENTS The following citations represent the findings of a Resurvey with complaint investigations #173121, #173149, #174935, #175059, and #173121 for the above named Assisted Living facility conducted on 10/17/22, 10/18/22, and 10/19/22.	S 000		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a) The facility reported a census of 24 residents(R). The sample included three residents and one focused record review. Based on interview and record review the Operator failed to ensure one (117) of three sampled residents had a functional capacity screen completed by designated staff on or before admission to the assisted living	S3080		

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

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S3080	Continued From page 1 facility to determine the resident's functional capacity. Findings included: - Review of R117's electronic medical record revealed he moved into the facility on 10/01/22 with diagnoses of chronic knee and joint pain. R117's "Functional Capacity Screen" completed on 10/03/22 revealed staff completed it two days after the resident moved into the facility. On 10/18/22 at 02:25 PM "Administrative Staff/Licensed Nurse" A reported she normally completed the "Functional Capacity Screen" on the day the resident moved in, but he moved in on the weekend, so she completed it the next Monday. Review of the undated "Assisted Living Functional Capacity Screen" policy revealed that on or before each individual's admission to this assisted living facility a licensed nurse, a licensed social worker, or the Administrator/Operator will conduct a screening to determine the individual's functional capacity. The Operator failed to ensure designated staff completed a Functional Capacity Screen on or before admission to the assisted living facility.	S3080		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s	S3081		

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functional capacity according to the following requirements:
(1) At least once every 365 days;
(2) following any significant change in condition as defined in K.A.R. 26-39-100; and
(3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-201 (c)(2)

The facility reported a census of 24 residents (R). The sample included three residents and one focused record review. Based on observation, interview and record review the operator failed to ensure staff completed a "Functional Capacity Screen" for one (R119) of three sampled residents and for 1 (R120) of 1 focused record review following a significant change in condition.

Findings Included:

- Review of R119's electronic medical record revealed she moved into the facility on 02/09/21 with diagnoses of dementia and dysphagia.

R119's "Functional Capacity Screen" (FCS) dated 03/04/22 revealed the resident was independent with walking/mobility and eating.

Observation on 10/18/22 at 11:13 AM "Certified Nurse Aide" (CNA) H pushed the resident to the dining room via wheelchair. CNA H got the resident two styrofoam cups and assisted the

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resident to drink from them.

Observation on 10/18/22 at 12:09 PM "Dietary Staff" J brought R119 her noon meal which consisted of a bowl of ham and beans with bite size chunks of ham in it, corn bread, oven fried potatoes, and spinach. CNA H handed the resident her spoon and she gradually took one bite of the ham and beans independently. After taking one bite she just kept biting on the empty spoon. CNA H then proceeded to help the resident to eat, encouraging, cueing, and hand-over-hand assisting her to finish eating her noon meal.

Observation on 10/19/22 at 09:09 AM Hospice staff came in the facility to get resident R119 up for the day. Hospice staff assisted the resident to sit on the side of the bed, put a gait belt on her, and then helped her to stand up and pivot transfer from the bed to the wheelchair. Staff then pushed the wheelchair into the bathroom to help the resident finish morning cares.

Observation on 10/19/22 at 10:18 AM CNA K sat with the resident and fed her oatmeal. The resident also had a plate of bitesize pieces of sausage and scrambled eggs, but CNA K stated she had difficulty eating the sausage.

Observation on 10/18/22 at 05:30 PM dietary staff served the resident a taco salad mix on top of a tortilla shell -- it included hamburger, tomatoes, and lettuce. CMA K cut it up into pieces and took out the hard parts of the tortilla shell stating the resident would not be able to eat it. CMA K stated if the food is tough or if R120 had a hard time chewing it, she will just roll it

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around in her mouth like a piece of candy. CMA K then proceeded to sit beside the resident and help her eat her food.

On 10/19/22 at 11:26 AM CNA K reported staff needed to help her with all her activities of daily living and the resident was not able to propel herself in the wheelchair to meals and back to her room. She stated on a good day, with the foot pedals off she can move around a bit but not to a specific location. CNA K reported the resident needed quite a bit of help with eating now, but on occasion she could hold her cup and drink.

On 10/19/22 at 03:25 PM "Administrative Licensed Nurse" C confirmed "Administrative Staff/Licensed Nurse" A failed to complete a FCS when the resident was no longer independent with eating and mobility.

Review of the undated "Assisted Living Functional Capacity Screen" policy revealed designated facility staff would conduct a screening following any significant change in condition.

The operator failed to ensure designated staff completed a FCS when R119 had a significant change in status.

- Review of R120's electronic medical record revealed she moved into the facility on 02/09/21 with diagnosis of neurocognitive disorder with Lewy bodies.

R120's "Functional Capacity Screen" (FCS) dated 03/04/22 identified the resident as

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independent with transfers, walking/mobility and with eating. It did not identify the resident used a wheelchair for mobility assistance. It did not identify the resident had any inappropriate distuptive behaviors.

R120's "Progress Notes" revealed on 08/29/2022 at 10:48 AM direct care staff reported the resident hitting, screaming, and pulling staff's hair when they attempted to get her up in the morning. Staff provided assistance of two staff to get her up in the morning related to behaviors. The resident refused medications when in a bad mood and staff were to provide redirection and approach later to try again.

On 10/18/22 at 10:09 AM CNA K and CMA D went to assist the resident to get up for the day. The resident said she wanted to stay in bed, she was so tired, and staff continued to gently encourage her to get up for the day. CMA D continued to encourage her, CNA K helped her to sit up and then CMA D proceeded to assist her to side on the side of the bed. CNA K had put R120's walker in front of her and CMA D helped resident to reach for walker and stand up. The resident then walked very slowly with staff holding onto her and helping push the walker into the bathroom then she sat on the toilet.

On 10/18/22 at 10:10 AM CNA K reported R120 was not independent with eating, walking/mobility or with transfers. Staff helped her cut her meat, cue her, and helped her get started eating sometimes. We had to help lift her off the bed and once she got stood up, she can usually walk with staff holding onto her and guiding her and the walker.

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S3081	Continued From page 6 On 10/18/22 at 05:30 PM dietary staff J served the resident a taco salad mixture on a tortilla shell. The resident started to eat it independently but could not eat the shell. CNA K cut the residents food and shell into smaller pieces and the resident resumed eating. On 10/19/22 at 03:30 PM "Administrative Licensed Nurse" C acknowledged "Administrative Staff/Licensed Nurse" A should have completed a new FCS to identify the resident had a significant change. Review of the undated "Assisted Living Functional Capacity Screen" policy revealed designated facility staff would conduct a screening following any significant change in condition. The Operator failed to ensure designated staff completed a FCS when R120 had a significant decline in functional ability.	S3081		
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:	S3085		

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S3085	Continued From page 7 (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)(3) The facility reported a census of 24 residents (R). The sample included three residents and one focused record review. Based on record review and interview, the administrator failed to ensure designated staff completed the Negotiated Service Agreement/Health Care Service Plan for three (R117, R118, R119) of three sampled residents based on the resident's "Functional Capacity Screen" and service needs, which included a description of the services the resident received, the provider of each service, and payment source if the service is provided by an outside resource. Findings included: - Review of R117's electronic medical record revealed he moved into the facility on 10/01/22 with diagnoses of chronic knee and joint pain. R117's "Functional Capacity Screen" dated 10/03/22 identified the resident needed physical assistance to manage his medications and was unable to manage his medical treatments. It also identified he had impaired short-term memory,	S3085		

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memory/recall, and decision making.

R117's "Negotiated Service Agreement" dated 10/03/22 revealed the facility provided the supervised nursing service of medication assistance and [facility] was responsible for provision of this service.

The NSA failed to identify "who" provided this service as not all [facility] staff could provide assistance with management of medications.

On 10/18/22 at 04:22 PM "Certified Medication Aide" D reported the medication aides gave him his medications and set up his nebulizer treatments for him.

On 10/17/22 at 04:38 PM "Administrative Staff /Licensed Nurse" A reported only a "Certified Medication Aide and Licensed Nurse" were allowed to administer the residents their medications.

Review of the undated "Assisted Living Negotiated Service Agreement" policy revealed the residents "Nnegotiated Service Agreement will provide the following information; a description of the services the resident will receive, identification of the provider of each service, and identification of each party responsible for payment if outside resources provide a service.

The Operator failed to ensure R117's "Negotiated Service Agreement" included specifically which facility staff would be administering the resident his medications.

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S3085	Continued From page 9 - Review of R118's electronic medical record revealed the resident moved into the facility on 09/02/22 with diagnosis of major depressive disorder. R118's "Functional Capacity Screen" dated 09/02/22 identified the resident was independent with all activities of daily living but was unable to manage her medications and medical treatments, had impaired cognition, was at risk for falls and had impaired decision-making abilities. R118's "Negotiated Service Agreement" dated 09/02/22 revealed the facility provided the supervised nursing service of medication assistance and [facility] was responsible for provision of this service. On 10/18/22 at 04:22 PM "Certified Medication Aide" D reported the medication aides administered her medications. On 10/17/22 at 4:38 PM "Administrative Staff /Licensed Nurse" A reported only a "Certified Medication Aide or Licensed Nurse" were allowed to administer the residents their medications. Review of the undated "Assisted Living Negotiated Service Agreement" policy revealed the residents "Nnegotiated Service Agreement will provide the following information; a description of the services the resident will receive, identification of the provider of each service, and identification of each party responsible for payment if outside resources provide a service.	S3085		

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The Operator failed to ensure R118's "Negotiated Service Agreement" included specifically which facility staff would be administering the resident his medications.

- Review of R119's electronic medical record revealed she moved into the facility on 02/09/21 with diagnoses of dementia and dysphagia.

R119's "Functional Capacity Screen" (FCS) dated 03/04/22 revealed the resident needed physical assistance with bathing, dressing, toileting, and transfers. It also identified the resident was unable to manage her medications and medical treatments

R119's "Negotiated Service Agreement" (NSA) dated 03/01/22 revealed the facility provided the supervised nursing service of medication assistance and [facility] was responsible for provision of this service. The NSA failed to identify the resident received services for Hospice.

On 10/18/22 at 04:22 PM "Certified Medication Aide" (CMA) D reported the medication aides gave her medications. CMA D also reported the resident received Hospice services and the hospice aide came twice a week to bathe the resident.

On 10/17/22 at 04:38 PM "Administrative Staff /Licensed Nurse" A reported only a "Certified Medication Aide or Licensed Nurse" were allowed to administer the residents their medications.

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S3085	Continued From page 11 On 10/19/22 at 03:25 PM "Administrative Licensed Nurse" C confirmed the NSA needed to identify who provided the Hospice service and the payment source. Review of the undated "Assisted Living Negotiated Service Agreement" policy revealed the residents "Nnegotiated Service Agreement will provide the following information; a description of the services the resident will receive, identification of the provider of each service, and identification of each party responsible for payment if outside resources provide a service. The Operator failed to ensure R119's "Negotiated Service Agreement" included specifically "who" would be administering the resident his medications, who provided Hospice services, and who was responsible for the payment of those services.	S3085		
S3090 SS=D	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(c) The facility reported a census of 24 residents(R). The sample included three residents and one	S3090		

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S3090	Continued From page 12 focused record review. Based on interview and record review the Operator failed to ensure one (R117) of three sampled residents had an initial negotiated service agreement developed at admission to the facility. Findings included: - Review of R117's electronic medical record revealed he moved into the facility on 10/01/22 with diagnoses of chronic knee and joint pain. R117's "Negotiated Service Agreement" dated 10/3/22 revieal ed staff completed it two days after admission to the facility. On 10/18/22 at 02:25 PM "Administrative Staff/Licensed Nurse" A reported she normally completed the "Negotiated Service Agreement " on the day the resident moved in, but he moved in on the weekend, so she completed it the next Monday. Review of the undated "Assisted Living Negotiated Service Agreement" policy revealed " the Administrator/Operator will ensure the development of the initial negotiated service agreement at admission. The Operator failed to ensure 1 (R117) of 3 sampled residents had an initial Negotiated Service Agreement developed at admission to the facility.	S3090		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure	S3092		

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S3092	Continued From page 13 the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (d)(2) The facility reported a census of 24 residents (R). The sample included three residents and one focused record review. Based on observation, interview and record review the Operator failed to ensure staff reviewed/revised the "Negotiated Service Agreement" for one (R119) of three sampled residents and one (R120) of one focused review residents following the residents experiencing a significant change in status and need for change in services provided. Findings included: -- Review of R119's electronic medical record revealed she moved into the facility on 02/09/21 with diagnoses of dementia and dysphagia.	S3092		

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R119's "Functional Capacity Screen" (FCS) dated 03/04/22 revealed the resident was independent with walking/mobility and with eating.

R119's "Negotiated Service Agreement" dated 03/01/22 did not identify staff provided any services related to walking/mobility or that she had quarter bed rails on her bed. It identified staff would assist with cutting the resident's meat and opening containers as needed but did not identify staff would physically feed the resident as needed.

R119's "Care Plan" dated 02/09/22 identified the resident used a wheelchair. It did not identify staff helped the resident eat and needed to be served finger foods.

On 10/18/22 at 11:13 AM "Certified Nurse Aide" (CNA) H pushed the resident to the dining room via wheelchair. CNA H got the resident two styrofoam cups and assisted the resident to drink from them.

On 10/18/22 at 12:09 PM "Dietary Staff" J brought R119 her noon meal which consisted of a bowl of ham and beans with bite size chunks of ham in it, corn bread, oven fried potatoes, and spinach. CNA H handed the resident her spoon and she gradually took one bite of the ham and beans independently. After taking that bite she just kept biting on the empty spoon. CNA H then proceeded to help the resident to eat encouraging, cueing, and hand-over-hand assisting her to finish eating her noon meal.

On 10/19/22 at 09:09 AM Hospice staff came in

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the facility to get resident R119 up for the day. Hospice staff assisted the resident to sit on the side of the bed, they put a gait belt on her, and helped her to stand up with pivot transfer from the bed to the wheelchair. Staff then pushed the wheelchair into the bathroom to help the resident finish morning cares.

On 10/19/22 at 10:18 AM CNA K sat with the resident and fed her oatmeal. The resident also had a plate of bite sized pieces of sausage and scrambled eggs. CNA K stated resident had difficulty eating the sausage.

On 10/18/22 at 05:30 PM dietary staff served the resident a taco salad mix on top of a tortilla shell -- it included hamburger, tomatoes, and lettuce. CMA K cut it up into pieces and took out the hard parts of the tortilla shell stating the resident would not be able to eat it. CMA K stated if the food is tough or if R120 had a hard time chewing it, she will just roll it around in her mouth like a piece of candy. CMA K then proceeded to sit beside the resident and helped her eat her food.

On 10/19/22 at 11:26 AM CNA K reported staff needed to help her with all her activities of daily living and the resident was not able to propel herself in the wheelchair to meals or back to her room. On a good day with the foot pedals off she could move around a bit but not to a specific location. CNA K reported the resident needed quite a bit of help with eating now, but on occasion she could hold her cup and drink.

On 10/19/22 at 03:25 PM "Administrative Licensed Nurse" C confirmed "Administrative Staff/Licensed Nurse" A should have revised the

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NSA to identify the changes in services staff were providing the resident.

Review of the undated "Assisted Living Negotiated Service Agreement" policy revealed review of the "Negotiated Service Agreement will occur quarterly or with any significant change in conjunction with review of the Functional Capacity Screen".

The operator failed to ensure designated staff reviewed and revised R119's "Negotiated Service Agreement" when she experienced a significant changes in status.

- Review of R120's electronic medical record revealed she moved into the facility on 02/09/21 with diagnosis of neurocognitive disorder with Lewy bodies.

R120's "Functional Capacity Screen" (FCS) dated 03/04/22 identified the resident as independent with transfers, walking/mobility and with eating. It also did not identify the resident used a wheelchair for mobility assistance.

R120's "Negotiated Service Agreement" (NSA) dated 03/01/22 revealed staff would assist with cutting meat and opening containers as needed.

The resident's record failed to include a review/revision of the NSA to identify that the resident had aggressive behaviors toward staff when getting up in the mornings, that the resident required staff to physically feed her at times during meals and failed to include a review/revision when the resident started Hospice services.

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R120's record included a physician's order dated 08/30/22 for Hospice to evaluate and admitted for comfort services if appropriate and an order on 08/31/22 to start services with [name] of local Hospice company for comfort care.

R120's "Progress Notes" revealed on 08/29/2022 at 10:48 AM direct care staff reported the resident hitting, screaming, and pulling staff hair went attempt to get her up in the morning. Staff are providing assistance of two staff to get her up in the morning related to behaviors. The resident is also refusing medications when in bad mood and staff to provide redirection and approach later to try again.

The record also included a notebook with documentation of visits from the local Hospice company.

On 10/18/22 at 10:09 AM CNA K and CMA D went to assist the resident to get up for the day. The resident said she wanted to stay in bed, she was so tired, and staff continued to gently encourage her to get up for the day. As CMA D continued to encourage her CNA K helped her to sit up and then CMA D proceeded to assist her to side on the side of the bed. CNA K had put R120's walker in front of her and CMA D helped resident to reach for walker and stand up. The resident then walked very slowly with staff holding onto her and helping push the walker into the bathroom and sat on the toilet.

On 10/18/22 at 10:10 AM CNA K reported R120 was not independent with eating, walking/mobility or with transfers. Staff must

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S3092	Continued From page 18 help her cut her meat, cue her, and help her get started eating sometimes. We have to help lift her off the bed and once she gets stood up, she can usually walk with staff holding onto her and guiding her and the walker. On 10/18/22 at 05:30 PM dietary staff J service the resident a taco salad mixture on a tortilla shell. The resident started to eat it independently but could not eat the shell. CNA K cut the residents food and shell into smaller pieces and the resident resumed eating. On 10/19/22 at 03:30 PM "Administrative Licensed Nurse" C acknowledged "Administrative Staff/Licensed Nurse" A should have revised the NSA to include the changes to services provided for the resident when she had a significant change in status. Review of the undated "Assisted Living Negotiated Service Agreement" policy revealed review of the "Negotiated Service Agreement will occur quarterly or with any significant change in conjunction with review of the Functional Capacity Screen". The Operator failed to ensure designated staff reviewed/revised the NSA when R120 required more assistance with eating and started on Hospice services.	S3092		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement	S3101		

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S3101	Continued From page 19 and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (h) The facility reported a census of 24 residents (R). The sample included three residents and one focused record review. Based on interview and record review for 2 (R118 and R119) of three sampled residents the operator failed to ensure that everyone involved in the development of the negotiated service agreement signed the agreement. Findings included: - Review of R118's electronic medical record revealed the resident moved into the facility on 09/02/22 with diagnosis of major depressive disorder. R118's "Functional Capacity Screen" dated 09/02/22 identified the resident was independent with all activities of daily living but was unable to manage her medications and medical treatments, had impaired cognition, was at risk for falls and had impaired decision-making abilities. R118's "Negotiated Service Agreement" dated 09/02/22 failed to include the signatures of all who participated in completion of the agreement. On 10/18/22 at 05:50 PM "Administrative	S3101		

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Staff/Licensed Nurse A" reported the resident's child/guardian was not here when R118 moved from the long-term care facility or when she returned from the hospital and readmitted into the facility. Staff A reported she normally would have emailed her child to get signatures, but the papers were still with the resident's child.

Review of the undated "Assisted Living Negotiated Service Agreement" policy revealed the individuals involved in the development of the Negotiated Service Agreement will sign the agreement.

The operator failed to ensure everyone who participated in the development of R119's "Negotiated Service Agreement" signed it.

- Review of R119's electronic medical record revealed she moved into the facility on 02/09/21 with diagnoses of dementia and dysphagia.

R119's "Functional Capacity Screen" (FCS) dated 03/04/22 revealed the resident needed physical assistance with bathing, dressing, toileting, and transfers. It also identified the resident was unable to manage her medications and medical treatments

R119's "Negotiated Service Agreement" dated 03/01/22 failed to include the signatures of all who participated in the completion of the agreement.

On 10/19/22 at 03:25 PM "Administrative Licensed Nurse" C reported everyone who participate in the development of the "Negotiated Service Agreement" needed to sign it, including

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S3101	Continued From page 21 the resident's legal representative. Review of the undated "Assisted Living Negotiated Service Agreement" policy revealed the individuals involved in the development of the Negotiated Service Agreement will sign the agreement. The operator failed to ensure all who participated in the development of R120's negotiated service agreement signed it.	S3101		
S3102 SS=E	26-41-202 (i) Negotiated Service Agreement Service Received (i) Each administrator or operator shall ensure that each resident receives services according to the provisions of that resident ' s negotiated service agreement This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (i) The facility reported a census to 24 residents (R). The sample included three residents and one focused record review. Based on observations, interview, and record review for all residents in the facility, the operator failed to ensure the provision of activity services according to each resident's negotiated service agreement. This had the potential to affect all residents in the facility. - Review of the template for "[facility name]Assisted Living Negotiated Service Agreement" provided by "Administrative Staff/Licensed Nurse on 10/18/22 included	S3102		

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S3102	Continued From page 22 "[facility] will provide daily activities and encourage participation". Review of resident council minutes revealed the following: 02/27/22 - Providing activities is a work in progress and facility will not have an activity aide per home office until census is increased. 09/05/22 - Activity director in long term care is to come to assisted living once a day for 30 minutes to provide activities. Review of the October 2022 activity calendar for the week of 10/17/22 included 10:00 AM exercises and then a 02:00 PM activity. Observations from 10/17/22 to 10/19/22 from 02:10 PM to 05:00 PM daily revealed the facility provided no 10:00 AM exercise or other substitute activity and on 10/18/22 there was an activity, "fun with balls" scheduled but activity did not occur. Observation on 10/18/22 at 01:00 PM facility had a resident council meeting with 12 residents present. Their concerns related to activities included not having scheduled activities, wanting to be able to go on shopping trips to get supplies, and wanting a large TV in the dining room so that they could do morning exercises while watching chair exercises. On 10/18/22 at 02:48 PM "Certified Nurse Aide" (CNA) H reported the facility has not had an activity director since February of 2022 and the direct care staff have had to clean all resident rooms and do all the laundry as well. CNA H	S3102		

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S3102	Continued From page 23 stated the residents have asked for a big screen TV so they can do chair yoga in the morning. CNA H stated residents want to be able to do more self-directed activities such as watching football games and have a movie night. On 10/19/22 at 11:26 AM CNA K reported staff try to do the activities but stated they had to answer lights and take care of the residents. There is a volunteer who comes in to do bingo. On 10/19/22 at 04:00 PM "Administrative Staff" B acknowledged the staff had not been doing activities as planned. Review of the undated "Assisted Living Negotiated Service Agreement" Policy included the development of the initial negotiated service agreement included, but not limited to the provision of activities. The operator failed to ensure activities were provided according to residents' "Negotiated Service Agreements" and according to the activity calendar as planned.	S3102		
S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications.	S3186		

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

The facility reported a census of 24 residents (R). The sample included three residents and one focused record review. Based on record review and interview the operator failed to ensure one (R117) of three sampled residents who self-administered some of their medications had a Negotiated Service Agreement that identified the responsible person for the administration and management of selected medications.

Findings included:

- Review of R117's electronic medical record revealed he moved into the facility on 10/01/22 with diagnoses of chronic knee and joint pain.

R117's "Functional Capacity Screen" dated 10/03/22 identified the resident needed physical assistance to manage his medications and was unable to manage his medical treatments. It also identified he had impaired short-term memory, memory/recall, and decision making.

R117's "Negotiated Service Agreement" dated 10/03/22 revealed the facility provided the supervised nursing service of medication assistance. It failed to identify the resident self-administered his albuterol inhaler and his

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S3186	Continued From page 25 nebulizer medications once staff set it up for him. On 10/18/22 at 02:25 PM "Administrative Staff/Licensed Nurse" A acknowledged the resident's "Negotiated Service Agreement" did not include that the resident would self-administer his albuterol inhaler and his nebulizer medications once staff set it up for him. The Operator failed to ensure R117, who self-administered some of his medications, had a "Negotiated Service Agreement" that identified the responsible person for the administration and management of selected medications.	S3186		
S3200 SS=G	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the 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.	S3200		

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S3200	Continued From page 26 This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) The facility reported a census of 24 residents (R). The sample included three residents and one focused record review. Based on observation, interview, and record review the operator failed to ensure designated staff ordered and administered Hydrocodone-Acetaminophen (a narcotic pain medication) for 1 (R117) of 3 sampled residents to ensure he received his pain medication as ordered by the medical provider every 6 hours for chronic pain. Interview and record review revealed staff failed to reorder the medication in a timely manner, which resulted in the resident not receiving six consecutive doses due to unavailability causing the resident to have increased pain rated at a 10 out of 10 (worst level of pain experienced) during the time he did not receive his medications. Findings included: - Review of R117's electronic medical record revealed he moved into the facility on 10/01/22 with diagnoses of chronic knee and joint pain. R117's "Functional Capacity Screen" dated 10/03/22 identified the resident needed physical assistance to manage his medications and was unable to manage his medical treatments. It also identified he had impaired short-term memory, memory/recall, and decision making. R117's "Negotiated Service Agreement" dated 10/03/22 revealed the facility provided the	S3200		

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supervised nursing service of medication assistance.

R117's "Medication Administration Record" (MAR) for October 2022 included a section for staff to administer Hydrocodone-Acetaminophen (narcotic pain medication) tablet 7.5-325 milligrams (mg), 1 tablet every six hours for chronic pain. It also identified the resident received daily Meloxicam (anti-inflammatory) for joint pain, was to have Voltaren Gel 1% (topical for arthritis pain) that he could self-apply for knee pain, and Tylenol (pain/fever) he could take as needed every eight hours for pain.

The October 2022 MAR revealed 13 times staff failed to initial administration of the Hydrocodone-Acetaminophen, and 3 times from 10/18/22 to 10/19/22 that included a #9 to identify a concern regarding the administration of the medication and to refer to the progress notes. The October MAR did not include any progress notes to indicate what the concerns were related to the administration of the medication.

The October MAR also included documentation of CMA staff asking the resident to rate his pain on a scale of 1-10, with 10 being the worst, at 06:00 AM and 06:00 PM. The record revealed that on 10/18/22 at 06:00 AM he rated his pain at a 10, and at 06:00 PM at a 9 out of 10 on the pain scale. On 10/20/22 at 06:00 AM he rated his pain at a 0 (zero) after receiving pain medications at midnight.

Review of the resident's progress notes lacked evidence of a nursing assessment for pain

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related to the resident not receiving his narcotic pain medication or evidence that the physician was contacted regarding the resident not receiving his medication.

On 10/18/22 at 09:50 AM, R117 stated he stated he had a lot of pain in his knees and his hands and the only medication the resident could keep in his room and self-administer was his albuterol inhaler (asthma). He reported the staff brought his medications, including his pain medications to him. R117 stated the facility forgot to order his pain medications so he had to go without until it became available.

On 10/18/22 at 12:17 PM, R117 stated that he missed out on his morning and his noon pain medication because it had not come in from the pharmacy yet. He shook his head and then walked back to his room.

Observation on 10/18/22 at 05:00 PM, R117 talked to "Certified Medication Aide" (CMA) D and asked her if his pain medication had come in yet and she told him not yet. She assured him that the nurse had been told it was not at the facility and the nurse would take care of it. R117 asked CMA D to bring him some Tylenol with his medications. Surveyor followed the resident to his room, and he stated on a scale of 1-10 with 10 being the worst pain, it was a nine. He said the Tylenol would bring the pain down a little, but not like the pain pill did. The resident reported he did not have any Voltaren gel to apply to the areas of pain, because he was not allowed to keep anything like that in his room.

Observation on 10/19/22 at 07:50 AM the

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resident walked to the medication cart and asked CMA E for his pain medication, and she looked and said it still had not been delivered yet. He then asked her to bring him some Tylenol and walked down to his room.

On 10/19/22 at 07:56 AM CMA E reported she was a new employee at the facility and was not sure what the process was for ordering medications, because some of them came every month and others did not. Stated she would talk to the pharmacy and see why his medications were not here.

On 10/19/22 at 11:55 AM, R117 sat at his table for lunch and had on a wrist brace. He looked at the surveyor and reported he had the CMA put bio freeze (pain cream) all over his hand so will see if might help. He also confirmed his pain medication had not arrived for him to receive his noon dose.

On 10/18/22 at 04:22 PM CMA D reported she had told "Administrative Operator/Licensed Nurse" A the other day that he needed to have his narcotic pain medication ordered. CMA D confirmed that he had not received it since she came in at 06:00 AM and he would not get his 06:00 PM dose if it did not come in this evening. CMA D stated her understanding of the process to order narcotic medications was to notify "Administrative Operator/Licensed Nurse" A and she would contact the physician to write a prescription to send to the pharmacy to get the medication. She stated that some medications were on a reoccurring cycle fill, but not the narcotics. She stated the process if a medication was not available, was they told Administrative

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Operator/Licensed Nurse A, and she was supposed to call the pharmacy and find out why and call the physician if needed.

On 10/19/22 at 09:38 AM CMA E reported the pharmacy told her they just received a text early this morning from Administrative Operator/Licensed Nurse A and are waiting on a prescription from the physician. CMA E reported "Administrative staff" B called the medical provider to get a prescription to the pharmacy right away and the medication should arrive later today.

On 10/19/22 at 04:01 PM "Administrative Licensed Nurse" C stated she expected the CMA to reorder narcotic medications when there is a 3-day supply left to ensure that if the pharmacy needed a prescription, it could be provided and then reviewed again the next day to make sure the facility would receive the medication before it runs out.

On 10/19/22 at 04:05 PM Administrative staff B stated the medical provider was notified on 10/18/22 of the need to send a prescription to the pharmacy. The medical provider sent the prescription to the wrong pharmacy. The medical provider sent one to the correct pharmacy today so he should get his pain medications this evening. She acknowledged the medication should have been ordered sooner to ensure the resident did not go without pain medication.

Review of the "Medication Orders and Receipt Record" policy dated 10/2021 revealed " ... The facility shall document all medications that it orders and received ... Medications should be

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S3200	Continued From page 31 ordered in advance, based on the dispensing pharmacy's required lead time." The Operator failed to ensure professional standards of practice for medications when designated staff failed to order R117's pain medications timely, to ensure he received his pain medications as ordered, and did not experience severe pain.	S3200		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 24 residents (R). The sample included three residents and one focused record review. Based on interview and record review the operator failed to ensure the record contained documentation of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken for three (R117, R118, R119) of three sampled residents. Findings included: - Review of R117's electronic medical record	S3261		

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S3261	Continued From page 32 revealed he moved into the facility on 10/01/22 with diagnoses of chronic knee and joint pain. R117's "Functional Capacity Screen" dated 10/03/22 identified the resident needed physical assistance to manage his medications and was unable to manage his medical treatments. It also identified he had impaired short-term memory, memory/recall, and decision making. R117's "Negotiated Service Agreement" dated 10/03/22 revealed the facility provided the supervised nursing service of medication assistance. R117's October 2022 MAR revealed 13 times staff failed to initial administration of the Hydrocodone-Acetaminophen, and 3 times from 10/18/22 to 10/19/22 that included a #9 to identify a concern regarding the administration of the medication and to refer to the progress notes. The October MAR did not include any progress notes to indicate what the concerns were related to the administration of the medication. Review of the resident's "Progress Notes" (PN included the following documentation: PN dated 10/13/22 the resident received the flu vaccine but failed to include follow for possible adverse reactions. The record also lacked evidence of a nursing assessment for pain related to the resident not receiving his narcotic pain medication or evidence that the physician was contacted regarding the resident not receiving his medication.	S3261		

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On 10/19/22 at 03:20 PM "Administrative Licensed Nurse" C reported she expects the nurses to document in the residents record anytime anything out of the normal happens which includes getting a vaccine or not having medications available for administration.

The operator failed to ensure the residents record included documentation of monitoring for adverse reactions after the resident received a flu shot and assessing the resident for pain when his pain medication was not available.

- Review of R118's electronic medical record revealed the resident moved into the facility on 09/02/22 with diagnosis of major depressive disorder.

R118's "Functional Capacity Screen" dated 09/02/22 identified the resident was independent with all activities of daily living but was unable to manage her medications and medical treatments, had impaired cognition, at risk for falls and had impaired decision-making abilities.

R118's "Negotiated Service Agreement" dated 09/02/22 identified staff would provide supervised nursing services related to medication assistance and management of behavioral symptoms.

R118's September 2022, "Medication Administration Record" revealed 11 times the resident refused or did not get her Risperidone (an antipsychotic).

R118's October 2022 MAR revealed the resident refused or did not get her bedtime Risperidone

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S3261	Continued From page 34 11 out of 18 times. The resident's record lacked documentation of a nurse assessing and attempting to determine why the resident refused her Risperidone. An interview on 10/17/22 at 03:09PM R118 reported she felt like the doctor and staff were trying to make her take a drug that that she thinks is a "killer". She stated it was "Risperidone, a psych drug". She stated she did not want to take it because it made her feel strange and dizzy. On 10/18/22 at 04:22 PM "Certified Medication Aide" (CMA) D reported R118 is alert and oriented and independent in all her daily cares except staff give her medications. CMA D confirmed the resident refused to take her Risperidone when it was scheduled during the daytime. On 10/19/22 at 03:40PM "Administrative Licensed Nurse" C reported residents can refuse cares and medications. R118 did not understand why she needed to take the Risperidone and thought she was fine without it. Nurse C acknowledged she would expect to see documentation in R118's medical record of the nurse assessing why the resident did not want to take the medication and notifying the physician of the resident's refusal. The operator failed to ensure designated staff documented in the residents record her refusals of medications, reasons for refusals and nursing assessment of resident's status related to refusals.	S3261		

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- Review of R119's electronic medical record revealed she moved into the facility on 02/09/21 with diagnoses of dementia and dysphagia.

R119's "Functional Capacity Screen" (FCS) dated 03/04/22 revealed the resident needed physical assistance with bathing, dressing, toileting, and transfers. It also identified the resident was unable to manage her medications and medical treatments

R119's "Negotiated Service Agreement" dated 03/01/22 identifies staff would help with activities of daily living and would administer medications.

Review of R119's "Progress Notes" (PN) revealed the following:

PN dated 04/29/2021 revealed the resident had a heart monitor on and kept taking the patches off. The record lacked documentation the testing was completed properly if resident continued to remove patches, and the results of the testing.

PN dated 05/16/2022 revealed the "Certified Nurse Aide" called the nurse and reported the resident was not responsive and breathing shallow and unable to obtain vitals. Nurse told CNA to contact 911. The record lacked follow up as to the resident's status related to unresponsive episode and possible transfer to hospital.

PN 07/05/22 revealed the resident's diet was changed to mechanical soft meat related to weight loss as well as implementing a nutritional supplement three times a day. Record lacked

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S3261	Continued From page 36 follow up if the resident's weight/nutritional status improved or continued to decline. PN dated 08/22/22 revealed resident declined and required assistance of two staff for transfers. A local Hospice was to come and assess resident status. Record lacked follow up as to resident's decline and possible significant change in status. PN also revealed on 09/20/22 resident received Covid booster and on 10/13/22 received flu vaccine. The record lacked evidence of follow up for possible adverse reactions to the booster and the flu vaccine. On 10/19/22 at 03:23 PM "Administrative Licensed Nurse" C reported she expected the nurse to document anything out of the normal. They needed to document what they did and follow up with the results for the residents, including monitoring for the side effects after getting vaccines and changes in status. The operator failed to ensure R119's record contained documentation of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action take.	S3261		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency	S3280		

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S3280	Continued From page 37 management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3)(4) The facility reported a census of 24 residents. Based on record review and interview for all residents and all facility employees, the Operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly reviews of the facility's emergency management plan with employees and residents and failed to have evidence of an emergency drill conducted at least annually that included the evacuation of residents to a secure location. Findings included: - On 10/17/22 at 02:10 PM surveyor arrived at the facility to complete the Resurvey. At 02:20 PM, surveyor sent an email to "Administrative Staff/Licensed Nurse" A requesting the following information: 1. Evidence of the quarterly reviews of the	S3280		

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emergency management plan with employees and residents since the last survey - return within 2 hours.

Surveyor sent another email to "Administrative Staff/Licensed Nurse" A and "Administrative Staff" B on 10/17/22 at 01:49 PM letting them know they still needed to provide evidence of the quarterly reviews of the emergency management plan with employees and residents.

Review of the resident council minutes provided on 10/18/22 by "Administrative Staff/Licensed Nurse" A did not include any reviews of the emergency management plan with residents.

On 10/18/22 at 04:00 PM "Administrative Staff/Licensed Nurse" submitted the emergency management plan with multiple potential emergencies. She reported she could not find any information that the facility staff or resident's had reviewed the emergency management plan.

From 10/17/22 at 02:10 PM to 10/19/22 at 04:45 PM, the facility failed to provide documented evidence that the emergency management plan was reviewed quarterly with facility staff or with facility residents.

The operator failed to ensure designated staff reviewed the emergency management plan quarterly with residents and staff and failed to complete annual evacuation drills of residents to a secure location.

- On 10/17/22 at 02:10 PM surveyor arrived at the facility to complete the Resurvey. At 02:20 PM, surveyor sent an email to "Administrative

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S3280	Continued From page 39 Staff/Licensed Nurse" A requesting the following information: Evidence of the last two-yearly evacuation drills - please return within 2 hours. (2021 and 2022) On 10/18/22 at 09:13 AM "Administrative Staff/Licensed Nurse" A stated the facility completed an evacuation drill on 08/12/22 related to a gas smell but had not been able to find and emergency evacuation drill for 2021. The operator failed to ensure designated staff completed an annual emergency evacuation drill for 2021.	S3280		
S3290 SS=E	26-41-206 (a) (b) Dietary Services (a) Provision of dietary services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. If the administrator or operator of the facility establishes a contract with another entity to provide or coordinate the provision of dietary services to the residents, the administrator or operator shall ensure that entity ' s compliance with these regulations. (b) Staff. The supervisory responsibility for dietetic services shall be assigned to one employee. (1) A dietetic services supervisor or licensed dietician shall provide scheduled on-site supervision in each facility with 11 or more residents. (2) If a resident ' s negotiated service agreement	S3290		

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S3290	Continued From page 40 includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (a) The facility reported a census of 24 residents (R). The sample included three residents and one focused record review. Based on observation, interview, and record review the operator failed to ensure 1 (R119) of 3 sampled residents and one (R120) of 1 focused review received a mechanically altered diet according to the residents' medical providers orders. Findings included: - Review of R119's electronic medical record revealed she moved into the facility on 02/09/21 with diagnoses of dementia and dysphagia. R119's "Functional Capacity Screen" (FCS) dated 03/04/22 revealed the resident needed physical assistance with bathing, dressing, toileting, and transfers. It also identified the resident was unable to manage her medications and medical treatments R119's "Negotiated Service Agreement" dated 03/01/22 identifies staff would help with activities	S3290		

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of daily living and would administer medications.

R119's medical provider orders dated 07/22/22 revealed orders for a regular diet, mechanical soft texture with regular liquids.

Review of R119's "Progress Notes" revealed on 07/05/22 revealed the resident's diet was changed to mechanical soft for meat related to weight loss as well as implementing a nutritional supplement three times a day. There is no follow up if the resident's weight/nutritional status improved or continued to decline.

On 10/18/22 at 12:09 PM dietary staff I brought the resident a bowl of ham and beans with chunks of ham in it.

On 10/18/22 at 05:30 PM dietary staff I served the residents a tortilla shell with taco fixings on top of it. Dietary staff I stated normally she "would not serve a resident on a mechanical soft diet lettuce but taco salad is pretty boring without the lettuce". "Certified Nurse Aide" H sat beside the resident and removed parts of the tortilla shell and stated the resident had difficulty chewing hard or tough foods.

On 10/19/22 at 10:18 AM "Certified Nurse Aide" (CNA) K sat beside the resident and fed R119 her oatmeal. A plate with chunks of sausage and scrambled eggs sat beside the resident. CNA K stated the resident had a hard time eating the sausage.

On 10/19/22 at 10:19 AM "Dietary Staff " J looked at the plate with eggs and pieces of sausage and confirmed it was not a mechanical

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soft diet. She took the plate back to the kitchen and later brought out a plate with ground up sausage and scrambled eggs.

The operator failed to ensure dietary staff served R119 a mechanically soft diet as ordered.

- Review of R120's electronic medical record revealed she moved into the facility on 02/09/21 with diagnosis of neurocognitive disorder with Lewy bodies.

R120's "Functional Capacity Screen" (FCS) dated 03/04/22 identified the resident as independent with transfers, walking/mobility and with eating.

R120's "Negotiated Service Agreement" (NSA) dated 03/01/22 revealed staff would assist with cutting meat and opening containers as needed. It failed to identify staff were to provide a mechanically altered diet.

R120's record included a medical provider's order dated 07/05/22 for a regular diet, mechanical soft texture due to chewing problems and weight loss.

On 10/18/22 at 05:30 PM dietary staff I served the residents a tortilla shell with taco fixings on top of it. Dietary I stated normally she "would not serve a resident on a mechanical soft diet lettuce but taco salad is pretty boring without the lettuce". After dietary staff I had served the resident, "Certified Nurse Aide" H cut the resident's food and removed part of the tortilla shell stating it would be too hard for the resident to eat.

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	N087053	A. BUILDING: _____ B. WING _____	10/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3290	Continued From page 43 On 10/19/22 at 10:18 AM the resident had been served a plate with bite size cut up pieces of sausage and some scrambled eggs. On 10/19/22 at 10:19 AM "Dietary Staff " J looked at the plate with eggs and pieces of sausage and confirmed it was not a mechanical soft diet. She took the plate back to the kitchen and later brought out a plate with ground up sausage and scrambled eggs. The operator failed to ensure dietary staff served R119 a mechanically soft diet as ordered.	S3290		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: K.A.R 26-41-207(c)	S3310		

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S3310	Continued From page 44 The facility reported a census of 24 residents(R). The sample included three residents and one focused record review. Based on interview and record review for two sampled residents (R117 and R118) and four of five newly hired employee records the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This failure effected all residents who lived in the Assisted Living facility. Findings included: - Review of R117's electronic record revealed the resident moved into the facility on 10/01/22. The record showed "Administrative Staff/Licensed Nurse administered the resident's 2-step TB skin tests on 10/03/22 and 10/12/22. The record failed to include the date it was read and the induration in millimeters (mm). On 10/19/22 at 03:07 PM "Administrative Licensed Nurse" C looked in R117's electronic record and confirmed it did not include the date it was read, who read it, and the results in millimeters (mm) of induration. - Review of R118's electronic medical record revealed the resident moved into the facility on 09/02/22. The record showed "Administrative Staff/Licensed Nurse administered the resident's 2-step TB skin tests on 09/02/22 and on 09/12/22. The record failed to include the date it was read, who read it, and the induration in millimeters (mm).	S3310		

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S3310	Continued From page 45 On 10/19/22 at 03:07 PM "Administrative Licensed Nurse" C looked in R118's electronic record and confirmed it did not include the date it was read, who read it, and the results in millimeters (mm) of induration. Review of the "Tuberculosis (TB) Guidelines for Adult Care Homes" dated June 2013 revealed the following: Required documentation in resident's clinical record or employees filed needed to include: "Each resident's clinical record or employee's file shall contain documentation regarding the symptom screen review, skin testing, IGRA and chest x-rays (if applicable). Two-Step TST: 1. Name and address of entity where testing took place. 2. Date each TST was administered 3. Date each TST was read. 4. Results of each TST in millimeters (mm) of induration. 5. Signature of representative verifying the two-step TST was administered and read. For R117 and R118 the Operator failed to ensure designated staff completed a 2-step TB skin test and included the required information in their medical record. - Review of four of fve newly hired employees file revealed the following: "Certified Medication Aide" (CMA) D did not have a 2-step TB skin test completed.	S3310		

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S3310	Continued From page 46	S3310		

"Certified Medication Aide" E did not have a 2-step TB skin test completed. .

"Certified Medication Aide F had one TB skin test completed but did not have a second TB skin test.

"Certified Nurse Aide" (CNA) G did not have a TB symptom screen completed.

The records revealed all 4 employees lacked TB testing according to TB guidelines.

On 10/19/22 at 03:09 PM "Administrative Licensed Nurse" C reported for new employees we do a symptom screen and a two step-skin test.

On 10/19/22 at 04:30 PM, "Administrative Staff" B stated she would look through the employee records and send their TB symptom screens and TB skin tests via email.

On 10/19/22 at 08:21 PM "Administrative Staff" B sent three of the five newly hired employees TB symptom screen information and stated she would send the other two on 10/20/22.

As of 10/20/22 at 02:58 PM surveyor had not received additional employee TB symptom screens for "Administrative Staff/Licensed Nurse" and CNA G, or the TB skin tests for CMA D, CMA E, and CMA F.

Review of the "Tuberculosis, EMployee Screening for" policy revised on 10/2021 identified "all employees are screened for latent tuberculosis infection (LTBI) and active

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S3310	Continued From page 47 tuberculosis (TB) disease, using tuberculin skin test (TST) or interferon gamma release assay (IGRA) and symptom screening, prior to beginning employment". Review of the "Tuberculosis (TB) Guidelines for Adult Care Homes" dated June 2013 revealed the following: Each new employee shall have an initial TB symptom screen that includes the components of the "Tuberculosis Symptom Screen Questionnaire" within seven days of employment... Each new employee shall receive a 2-step skin test within seven days of employment... For five of five newly hired employees, the Operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		
S3400 SS=F	28-39-255 DIETARY AREAS (d) Dietary areas. A dietary area or areas shall provide for sanitary meal preparation or service for residents. (1) The facility shall provide disposal of waste by incineration, mechanical destruction, removal or a combination of these. The facility shall use containers with tightly fitting lids to store waste. (2) Ceilings in the dietary areas shall be cleanable by dustless methods, such as vacuum cleaning or wet cleaning. These areas shall not have exposed or unprotected sewer lines.	S3400		

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S3400	Continued From page 48 This REQUIREMENT is not met as evidenced by: KAR 28-39-255(d) The facility reported a census of 24 residents. Based on observations, interview, and record review the operator failed to ensure designated staff provided a dietary area that was sanitary for meal preparations. This had the potential to affect all residents in the facility. Findings included: - Observations on 10/17/22 at 03:43 PM of the kitchen area revealed the dishwasher area floor had dish racks and blanket on the floor - there was a blanket on the floor beside the ice machine. Multiple cabinets had peeling paint, including cabinets above food prep areas. The front of all the cabinets had food and grease spillage down the front of the doors and the vents above the stove were covered in grease. On 10/17/22 at 03:47 PM "Dietary Staff" J acknowledged the kitchen area was dirty and needed a deep cleaning. She stated the blanket on the floor by the ice machine is to keep any flooding from the dishwasher from that area. She stated a company was coming tomorrow to go through the dishwasher and drainage system to get it all fixed tomorrow. She also acknowledged the hood vents above the stove needed to be cleaned. "Dietary Staff" J stated that the administrator and owners know that the kitchen needs some serious cleaning, but it is a matter of finding time and staff to complete the job.	S3400		

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S3400	Continued From page 49 On 10/17/22 at 04:26 PM "Administrative Staff" B acknowledged the kitchen was dirty and needed to be thoroughly cleaned. The operator failed to ensure designated staff kept the dietary areas clean to provide a sanitary meal preparation and service for residents.	S3400		