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S 000	INITIAL COMMENTS The following citations represent the findings of the resurvey and complaint investigations #149472, #152893, #154377, #154544, #154991, #155584, #156283, #159283 and #159346 conducted on 04-26-21, 04-27-21, 04-28-21, 04-29-21, 05-03-21 and 05-04-21.	S 000		
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. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (b) The facility reported a census of 28 resident and they managed medications for 26 of those residents. Based on record review and interview the administrator/operator failed to ensure the negotiated service agreement reflected self-administration of some medications and failed to identify who was responsible for the administration and management of selected medications for 1 of 3 residents sampled for medication management review (#307).	S3186		

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

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S3186	Continued From page 1 Findings included: - Record review for resident #307 revealed an admission date of 05-01-2016 with diagnoses of heart failure, chronic obstructive pulmonary disease, asthma, hypertension, diabetes type 2, hypokalemia and pain. The annual functional capacity screen (FCS) dated 01-05-21 identified the resident with deficit in memory recall and needed physical assistance with medications. The comprehensive self-medication assessment dated 11-03-2020 completed by licensed nurse D identified the resident as capable to recognize each medication, correctly identify the resident she takes the medication, correctly states how frequently she should take the medications, correctly states the number of tablets she should take, correctly administers eye drops or ointments, accurately defines PRN (as needed) medications, properly administers inhaled medications without assistance and understands she should report side effects. An assessment document titled admission/annual/bi-annual/significant change assessment dated 12-14-2020 completed by licensed nurse D. She marked the summary portion of resident self-medications with No and under the specific section for self-medication assessment nurse D marked the resident does not self-medicate The document titled FCS/NSA (negotiated service agreement) dated 01-05-21 completed by licensed nurse D indicated the resident needed physical assistance with medications-A caregiver prepares medications for administration and	S3186		

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S3186	Continued From page 2	S3186		

assists the resident to take medications. The NSA did not identify if the resident self-administered some of her medications. Under section VI of the assessment the item #2 was not marked to indicate the resident self-administered all or some of their medications.

The document identified by licensed nurse C as the health service plan (HSP) which is also titled negotiated service agreement last revised on 03-03-21 directed staff to order, prepare, reorder and give medications to the resident. Monitor for side effects and report to the resident care coordinator. Under a section for diabetes the HSP directed facility licensed nurses and medication aides will administer the resident's medications and treatments according to physician's order. The HSP lacked any information related to the resident self-administering some of her medications.

Review of the April 2021 medication administration record (MAR) revealed the following medications were marked as self-administered by the resident: multiple minerals-Vitamins tablet, Citracal a calcium citrate-Vitamin D tablet, Coenzyme Q10, Vitamin C, and Vitamin D-3. The MAR also included orders for PRN use of acetaminophen for pain or fever with order for unsupervised self-administration.

During an interview on 05-03-21 licensed nurse C and D confirmed the resident self-administered some of her medications and the assessments, NSA and HSP lacked this information.

The administrator/operator failed to ensure the negotiated service agreement reflected the resident self-administered some of her

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S3186	Continued From page 3 medications and failed to identify who was responsible for the administration and management of selected medications for the this resident.	S3186		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g) (3) The facility reported a census of 28 residents and the facility managed medications for 26 of those residents. Based on observation and interview the administrator/operator failed to ensure a licensed nurse or licensed pharmacist labeled over-the-counter medications with the resident's full name for 6 residents whom the facility managed his/her medications (#134, #211, #264, #413 and #510). Findings included:	S3211		

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S3211	Continued From page 4 - The resident roster provided on 04-26-21 indicated the facility managed medications/treatments for 26 residents. On 04-26-21 at 1:13 PM certified medication aide (CMA) A opened the medication cart on the memory care unit. Observation revealed over-the-counter (OTC) medications for resident ##211 which were only labeled with the first name and initial of last name or the first name initial and the last name or just the first name and room number as follows: Calcium with first name and last name initial, Vitamin D-3 with initial of first name, last name and room number, Vitamin C with first name, initial of last name and room number, Centrum multivitamin with first name and room number on the lid and a box of dairy digestive labeled with the resident #211's first name and room number. During an interview on 04-26-21 at 1:19 PM CMA A said whichever staff received the OTC medication when the family brought it in usually write the resident's name or room number on the bottle. On 04-26-21 at 1:41 PM CMA B opened the medication cart for the 100 & 200 halls. Observation revealed OTC medications for resident ##264 which were only labeled with the first name and room number as follows: Milk of Magnesia, acetaminophen PM, multivitamin gummies, Vitamin C, low dose aspirin and Vitamin D-3. On 04-26-21 at 1:49 PM CMA B opened the medication cart for the 300 & 400 halls. Observation revealed an opened bottle of OTC acetaminophen ER (extended release) for	S3211		

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S3211	Continued From page 5 resident #413 which was only labeled with the resident's first name and room number. The cart had an open bottle of OTC fluticasone allergy relief nasal spray with no name and only the room number for resident #134, 3 cans of saline nasal spray with no name and identified by CMA B as belonging to resident #134. An open bottle of acetaminophen 500 milligrams labeled with a room number only and CMA B identified as resident #134's. The cart had a bottle of stool softener and a tube of preparation H ointment with only a room number and CMA B reported they belonged to resident #510. During an interview on 04-26-21 at 1:50 PM CMA B took a black marking pen out of her pocket to label the OTCs and said the CMAs were to write the names on the OTC medications, but she was not aware of the regulation for the resident's full name and by a licensed nurse or licensed pharmacist. The administrator/operator failed to ensure a licensed nurse or licensed pharmacist labeled over-the-counter medications with the resident's full name.	S3211		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication	S3215		

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S3215	Continued From page 6	S3215		

room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in 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) (4)

The facility reported a census of 28 residents. The facility identified 2 residents who required insulin injections managed by the facility. Based on observation, record review and interview the operator failed to ensure licensed nurses and certified medication aides could not administer medications beyond the medication manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated insulin pens once opened for 2 of 2 residents whose insulin the facility managed

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S3215	Continued From page 7	S3215		

(#134 and #189). The operator further failed to ensure a licensed nurse could not administer medication beyond the manufacturer's or pharmacy provider's recommended date of expiration for an opened bottle of tuberculosis testing solution.

Findings included:

- On 04-26-21 licensed nurse C provided the resident roster which identified 2 residents who received facility managed insulin pens (#134 and #189)

Observation on 04-26-21 at 1:41 PM revealed certified medication aide (CMA) B opened the medication cart for the 100 & 200 hall. In the top drawer were diabetic supplies and insulin pens managed by the facility. Observation revealed an open and used Tresiba insulin pen with resident name or date when opened. CMA B identified the pen as belonging to resident #189. She said she had opened on the previous Friday and had forgot to date it. At 1:49 PM CMA B opened the medication cart for the 300 & 400 hall. Observation revealed an opened Levemir insulin pen without a name or date opened and an open Novolog insulin pen without a name or date opened. CMA B identified both insulin pens belonged to resident #134.

Interview on 04-26-21 at 1:41 PM with CMA B revealed the CMAs would dial the insulin pen for the residents, place the needle on the pen and the residents would inject the medications. She confirmed the insulin pens were to be dated when opened.

On 04-26-21 at about 4:00 PM licensed nurse C confirmed the CMAs dialed the dose of the insulin

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S3215	Continued From page 8 for the residents and were expected to date the insulin with the first use to ensure they pen was not used past the manufacture's date. The Novolog Flex pen manufacture recommended to store opened insulin at room temperature for up to 28 days and discard even if insulin remained. The Levemir FlexTouch manufacture recommended to store opened insulin at room temperature for up to 42 days and discard even if insulin remained. The manufacture of Tresiba recommended to store in-use Tresiba at room temperature (below 86 degrees Fahrenheit), away from direct heat and light for up to 8 weeks without refrigeration and do not refrigerate once opened. The operator failed to ensure licensed nurses and certified medication aides could not administer medications beyond the medication manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated insulin pens once opened.	S3215		
S3240 SS=E	26-41-103 (c) Staff Development on Dementia (c) If the facility admits residents with dementia, the administrator or operator shall ensure the provision of staff orientation and in-service education on the treatment and appropriate response to persons who exhibit behaviors associated with dementia. This REQUIREMENT is not met as evidenced by:	S3240		

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S3240	Continued From page 9 KAR 26-41-103 (c) The facility reported a census of 28 residents and had a special care unit for residents with dementia/cognitive impairment. The census for the unit was 6 with 1 currently in the hospital. Based on interview and record review the administrator/operator failed to ensure the provision of staff orientation/education on the treatment and appropriate responses to persons who exhibit behaviors associated with dementia. Findings included: - On 04-26-21 licensed nurse C provided the resident roster which identified 6 resident resided on the special care unit for residents with dementia/cognitive impairment. On 04-27-21 Administrator E provided a list of personnel hired since the last survey. The list included 43 direct care staff who were hired after the last documented Dementia training held on 05-20-2020. Review of the personnel file for licensed nurse D, direct care staff A, H and J revealed no evidence of dementia training at the time of hire. Interviews on 04-27-21 with direct care staff G and H revealed each one was hired after 05-20-2020 and worked on the special care unit for dementia/cognitively impaired residents. Both direct care staff G and H said they had an orientation to the unit but did not have specific training on Dementia and behaviors at the time of hire. They confirmed some of the residents had behaviors of yelling out, wandering, resisting care or being physical.	S3240		

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S3240	Continued From page 10 An email from Administrator E on 04-29-21 at 3:01 PM she reported the facility held annual Dementia training every May. She said all staff are able to work in the memory care unit. She wrote the facility did not provide specific dementia training upon hire and only did the annual in-service. The administrator/operator failed to ensure the provision of staff orientation/education on the treatment and appropriate responses to persons who exhibit behaviors associated with dementia.	S3240		
S3320 SS=E	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981.	S3320		

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S3320	Continued From page 11 This REQUIREMENT is not met as evidenced by: KAR 28-39-254 (a) The facility reported a census of 28 residents. Based on observation, interview and record review the administrator/operator failed to ensure the facility was equipped and maintained to protect the health and safety of residents, personnel and the public regarding unlocked chemicals. Findings included: - During the initial tour on 04-26-21 which began at 1:07 PM revealed the open door into the employee area and off the central hallway had 2 spray bottles of Virex Tb disinfectant under the sink in an unlocked cabinet which were labeled hazardous to humans and a spray can of Snow & Ice labeled harmful or fatal if swallowed. Administrator E confirmed the door to the room should be shut and had a key pad locking mechanism. The memory care unit at 1:20 PM had a common bathroom off the activity area had a clear plastic cup container with a thick blue liquid in it sitting on the sink counter. Under the sink cabinet was a bottle of Olive/Clove oil labeled keep out of reach of children. In an unlocked activity cabinet was a spray bottle with handwritten on it "bleach". On 04-26-21 at 1:27 PM certified medication aide A confirmed the blue liquid was laundry detergent and should not be left out for residents to have access. She removed the bottle of Olive/Clove oil and placed it in the trash can in the bathroom. She then removed the spray bottle labeled bleach	S3320		

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and said all the chemicals are supposed to be in the locked cabinet.

On 04-26-21 at 2:02 PM the door to the hair salon freely opened. Observation revealed the following items not secured in a locked cabinet and all were labeled with cautionary statement of harmful/fatal/contact poison control or medical provider if swallowed or inhaled or to keep out of reach of children: to the right of the door a bottle of nail polish remover, to the left a spray can of air freshener, in the lower cabinet of the hair washing area which was partially open and a key in the lock; 2 spray bottles of Barbicide, a spray bottle of bleach and a jug of bleach, on the counter top a spray bottle of Odo-ban and a glass jar with a blue liquid which was identified as Barbicide. Under the sink sitting on the floor was 2 clear plastic containers and 1 of them had a blue liquid and was labeled Barbicide. In the compartment of the hair sink was a spray bottle of window cleaner, T-gel shampoo, 4 cans of hair spray, 3 cans of dry shampoo and a spray can of clipper-zide.

On 04-26-21 at 2:15 PM Administrator E when notified of the hair salon door being open said the door should automatically lock and had a key pad entry. She went to the hair salon and tried the door multiple times which would not stay latched/locked. She said she would call maintenance and have a staff member keep a visual on the door until maintenance could come to fix it.

On 04-26-21 at 2:35 PM observation of the dining room cabinets revealed a spray can of surface disinfectant with hazardous warning to call poision control or medical care provider. Licensed nurse C removed the can upon notification and

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S3320	Continued From page 13 said it should be kept in a locked cabinet for chemicals. Observation on 04-26-21 at 3:28 PM revealed the hair salon door was slightly open and no staff were visible in the area. At this time, Administrator E was informed of the findings and she removed all the chemicals from the hair salon until maintenance could come. Observation on 04-26-21 at 3:40 PM revealed in the unlocked public bathroom a spray bottle of disinfectant sat on the floor under the toilet tank which included cautionary statement to call poison control or a medical care provider is swallowed. Licensed nurse C was informed and said the chemical should not be left there and she removed it. The administrator/operator failed to ensure the facility was equipped and maintained to protect the health and safety of residents, personnel and the public regarding unlocked chemicals.	S3320		