STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087059	A. BUILDING: _____ B. WING _____	10/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CRESTVIEW	600 N 127TH STREET EAST WICHITA, KS 67206

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S 000	INITIAL COMMENTS The following citations represent the findings of an Re-Licensure Survey with complaint investigations 177515, 177684, 178420,178688, 179652, and 181502, for the above named Assisted Living Facility conducted on 10/19/2023 and 10/23/23.	S 000		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: K.A.R 26-41-201 (d) The facility reported a census of thirty-six residents(R). The sample included three residents five focused record reviews. Based on interview and record review, the executive director failed to ensure designated facility staff completed one (R6) of five focused record reviews "Functional Capacity Screen" accurately to reflect their functional ability and need for health care services. Findings included: - Review of R6's electronic medical record revealed he moved into the facility on 07/01/21 with a diagnosis of anoxic brain damage. On 10/19/23 at 07:35 AM Administrative	S3082		

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

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S3082	Continued From page 1	S3082		

Licensed Nurse A reported the "Functional Capacity Screen" and the "Negotiated Service Agreement" (FCS/NSA)are one document and the service plan in the electronic record is the health care service plan.

R4's FCS/NSA dated 03/29/23 identified the resident had cognitive impairment and wandering. It did not identify the resident had any socially inappropriate disruptive behaviors.

Review of R6's electronic record included the following medical provider documentation:

09/27/22 - Resident seen at staff request for possible UTI " as well as inappropriate behaviors including exposing and manipulating self in front living room area."
10/11/22 - Resident seen at staff request for ..."continued inappropriate behaviors including exposing and manipulating self in front living room area". Plan for "hypersexual behaviors/GERD (gastroesophageal reflux disease) add Tagemet 200 mg BID (twice a day)".
10/25/22 - Resident seen at staff request for "continued inappropriate behaviors. Patient had been found previous night in his bedroom fully unclothed with a female resident who was also disrobed. Staff report continued inappropriate sexual comments as well as sexual behaviors. Reporting behaviors to be worse with specific staff members who the patient seems to like."
11/22/22 - Resident seen at staff request for "continued inappropriate behaviors. Patient had been manipulating himself in living room in front of others and found in private rooms fully unclothed with a female resident who was also

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S3082	Continued From page 2 disrobed. Staff report continued inappropriate sexual comments as well as sexual behaviors". Plan "hypersexual behaviors/GERD - increase Tagemet to 400 mg BID." An interview on 10/19/23 at 06:11 AM Certified Medication Aide (CMA) I reported the resident had violent tendencies and would corner staff and say inappropriate things. He also had a sexual relationship with a resident and would wave her over to him and then they would go down to his room. An interview on 10/23/23 at 03:07 PM CMA J reported the resident had made different sexual comments toward her, but she did not think of them as behaviors. On 10/23/23 at 12:55 PM Administrative Staff A reported she would have expected R6's FCS to include socially inappropriate behaviors on the FCS/NSA dated 03/29/23 since the medical providers documentation included documentation of inappropriate sexual behaviors in the memory care living room. The executive director failed to ensure designated staff completed R6's FCS accurately related to socially inappropriate behaviors.	S3082		
S3085 SS=D	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	S3085		

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S3085	Continued From page 3 screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a)(2) The facility reported a census of thirty-six residents (R). The sample included three residents and five focused record reviews. Based on record review and interview for one (R6) of five focused record reviews the executive director failed to ensure a licensed nurse completed the "Negotiated Service Agreement" based on the resident's service needs including a description of the service and who provided the service related to inappropriate behaviors. Findings included: - Review of R6's electronic medical record revealed he moved into the facility on 07/01/21 with diagnosis anoxic brain damage. On 10/19/23 at 07:35 AM Administrative	S3085		

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S3085	Continued From page 4	S3085		

Licensed Nurse A reported the "Functional Capacity Screen" and the "Negotiated Service Agreement" (FCS/NSA) are one document and the service plan in the electronic record is the health care service plan.

R4's FCS/NSA dated 03/29/23 identified the resident had cognitive impairment and wandering. It did not identify the resident had any socially inappropriate disruptive behaviors or services related to behaviors.

Review of R6's electronic record included the following medical provider documentation:
06/14/22 - Behaviors - continue topical Ativan and oral Ativan as ordered.
09/27/22 - Resident seen at staff request for possible UTI " as well as inappropriate behaviors including exposing and manipulating self in front living room area."
10/11/22 - Resident seen at staff request for ..."continued inappropriate behaviors including exposing and manipulating self in front living room area". Plan for "hypersexual behaviors/GERD (gastroesophageal reflux disease) add Tagemet 200 mg BID (twice a day)".
10/25/22 - Resident seen at staff request for "continued inappropriate behaviors. Patient had been found previous night in his bedroom fully unclothed with a female resident who was also disrobed. Staff report continued inappropriate sexual comments as well as sexual behaviors. Reporting behaviors to be worse with specific staff members who the patient seems to like."
11/22/22 - Resident seen at staff request for "continued inappropriate behaviors. Patient had been manipulating himself in living room in front

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S3085	Continued From page 5 of others and found in private rooms fully unclothed with a female resident who was also disrobed. Staff report continued inappropriate sexual comments as well as sexual behaviors". Plan "hypersexual behaviors/GERD - increase Tagemet to 400 mg BID." An interview on 10/19/23 at 06:11 AM Certified Medication Aide (CMA) I reported the resident had violent tendencies and would corner staff and say inappropriate things. He also had a sexual relationship with a resident and would wave her over to him and then they would go down to his room. On 10/23/23 at 12:55 PM Administrative Staff A reported she would have expected the FCS/NSA to identify services related to inappropriate behaviors as identified in the medical providers notes. For R6, the executive director failed to ensure a licensed nurse developed the FCS/NSA to include the provision of services related to socially inappropriate behaviors.	S3085		
S3155 SS=D	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S3155		

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S3155	Continued From page 6 This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of thirty-six residents (R). The sample included three residents and five focused record reviews. Based on observation, interview, and record review the executive director failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services for one (R6) of five focused record reviews related to inappropriate behaviors. Findings included: - Review of R6's electronic medical record revealed he moved into the facility on 07/01/21 with diagnosis anoxic brain damage. On 10/19/23 at 07:35 AM Administrative Licensed Nurse A reported the "Functional Capacity Screen" and the "Negotiated Service Agreement" (FCS/NSA) are one document and the service plan in the electronic record is the health care service plan. R4's FCS/NSA dated 03/29/23 identified the resident had cognitive impairment and wandering. It did not identify the resident had any socially inappropriate disruptive behaviors or services related to behaviors. R6's Health Care Service Plan last revised on 03/29/23 included the following health care	S3155		

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S3155	Continued From page 7	S3155		

service interventions:
Help Daryl keep busy with a variety of activities to decrease the chance of wandering. Sometimes noise and too much activity can cause Daryl to begin to wander about and may increase the risk to exist seek. Help Daryl to find a more quiet area to spend some time
Daryl doesn't always understand what is taking place and may become agitated as a result. Remove resident from situations where increased agitation is noted. If agitation doesn't resolve, contact the nurse and doctor.
Sometimes Daryl's anxiety may increase even though there is no apparent reason for it. Signs that anxiety is increasing are pacing, wandering into other resident rooms, disrobing, inappropriate response to verbal communication, displays of violent/aggressive behavior towards staff and/or other residents, etc.

R6's Health Care Service plan lacked interventions related to the resident exposing himself and manipulating himself infront of others in the living room.

Review of R6's electronic record included the following medical provider documentation:
06/14/22 - Behaviors - continue topical Ativan and oral Ativan as ordered.
09/27/22 - Resident seen at staff request for possible UTI " as well as inappropriate behaviors including exposing and manipulating self in front living room area."
10/11/22 - Resident seen at staff request for ..."continued inappropriate behaviors including exposing and manipulating self in front living room area". Plan for "hypersexual behaviors/GERD (gastroesophageal reflux

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S3155	Continued From page 8	S3155		

disease) add Tagemet 200 mg BID (twice a day)".
10/25/22 - Resident seen at staff request for "continued inappropriate behaviors. Patient had been found previous night in his bedroom fully unclothed with a female resident who was also disrobed. Staff report continued inappropriate sexual comments as well as sexual behaviors. Reporting behaviors to be worse with specific staff members who the patient seems to like."
11/22/22 - Resident seen at staff request for "continued inappropriate behaviors. Patient had been manipulating himself in living room in front of others and found in private rooms fully unclothed with a female resident who was also disrobed. Staff report continued inappropriate sexual comments as well as sexual behaviors". Plan "hypersexual behaviors/GERD - increase Tagemet to 400 mg BID."

An interview on 10/19/23 at 06:11 AM Certified Medication Aide (CMA) I reported the resident had violent tendencies and would corner staff and say inappropriate things. He also had a sexual relationship with a resident and would wave her over to him and then they would go down to his room.

On 10/23/23 at 01:03 PM Administrative Licensed Nurse E reported she knew staff were provided education regarding redirecting R6 related to the sexual relationship he had with another female resident. Licensed Nurse E acknowledged the Service Plan should have included interventions related to the resident having inappropriate behaviors.

The executive director failed to ensure a licensed

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S3155	Continued From page 9 nurse developed and coordinated interventions related to the resident's inappropriate sexual behaviors as identified in the resident's medical providers notes.	S3155		
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. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (a)(1) The facility reported a census of thirty-six resident (R)s. The sample included three residents and five focused record reviews. Based on interview, and record review for one (R4) of three sampled residents, the executive director failed to ensure a licensed nurse	S3175		

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S3175	Continued From page 10 assessed R4 prior to self-injection of insulin to ensure she was able to self-inject her insulin safely and correctly once it had been prepared and dialed to the ordered dosage by the Certified Medication Aide. Findings included: - Review of R4's medical record revealed she moved into the facility on 09/22/23 with diagnosis of diabetes type II. On 10/19/23 at 07:35 AM Administrative Licensed Nurse A reported the "Functional Capacity Screen" and the "Negotiated Service Agreement" (FCS/NSA)are one document and the service plan in the electronic record is the health care service plan. R4's FCS/NSA dated 09/20/23 identified the resident needed physical assistance with management of her medications and medical treatments. It revealed the "nurse prepared and administered all medications per physicians' orders". R4's Service Plan included an intervention dated 09/20/23 that directed certified medication aides and licensed nurses to "Give insulin per doctor's orders, with staff supervision/independent. Review of R4's physicians orders included the following orders: Trulicity subcutaneous solution pen-injector, inject 03 milligrams (mg) one time per day every Friday. Insulin Detemir subcutaneous solution, inject 20 units at bedtime for diabetes.	S3175		

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S3175	Continued From page 11 Novolog FlexPen solution pen-injector inject 10 units with meals. The orders also included directions for Novolog sliding scale to be administered based upon the resident's blood sugar. Review of R4's admission nursing assessment dated 09/20/23 under the "Self medication" section had checked that the resident does not self medicate. On 10/23/23 at 11:27 AM Administrative Licensed Nurse B looked in the resident's chart and acknowledged the self-medication assessment portion of R4's nursing assessment had not been completed to identify the resident could safely and accurately self-inject her insulin. The administrator failed to ensure a licensed nurse assessed R4 to ensure she was able to self-inject her insulin safely and correctly after the insulin pen had been prepared and dialed to the correct dosage by a Certified Medication Aide.	S3175		
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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S3186	Continued From page 12	S3186		

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

The facility reported a census of thirty-six residents(R). The sample included three residents and five focused record reviews. Based on observation, interview, and record review the administrator failed to ensure one (R4) of three sampled residents who self-injected their insulin, had a Negotiated Service Agreement that identified the responsible person for the administration and management of selected medications.

Findings included:

- Review of R4's medical record revealed she moved into the facility on 09/22/23 with diagnosis of diabetes type II.

On 10/19/23 at 07:35 AM Administrative Licensed Nurse A reported the "Functional Capacity Screen" and the "Negotiated Service Agreement" (FCS/NSA)are one document and the service plan in the electronic record is the health care service plan.

R4's FCS/NSA dated 09/20/23 identified the resident needed physical assistance with management of her medications and medical treatments. It revealed the "nurse prepared and administered all medications per physicians'

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S3186	Continued From page 13 orders". F4's NSA failed to identify that the resident self-injected her insulin and the facility staff administered all other medications. R4's Service Plan included an intervention dated 09/20/23 that directed certified medication aides and licensed nurses to "Give insulin per doctor's orders, with staff supervision/independent. Observation on 10/19/23 at 11:05 AM Certified Medication Aide (CMA) D went into R4's room, checked her blood sugar then prepared and dialed the Novolog insulin pen for the resident to self-inject. CMA D handed R4 her insulin pen and the resident took the pen and poked herself and then pushed the plunger down and handed it back to CMA D. The executive director failed to ensure designated staff included in the FCS/NSA who was responsible for administration of selected medications when R4 chose to self--inject her insulin.	S3186		
S3214 SS=D	26-41-205 (g) (4) Sample & Indigent Medication Program Meds (g) (4) Licensed nurses and medication aides may administer sample medications and medications from indigent medication programs if the administrator or operator ensures the development of policies and implementation of procedures for receiving and identifying sample medications and medications from indigent medication programs that include all of the following conditions:	S3214		

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S3214	Continued From page 14 (A) The medication is not a controlled medication. (B) A medical care provider ' s written order accompanies the medication, stating the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration. (C) A licensed nurse or medication aide receives the medication in its original, unbroken manufacturer ' s package. (D) A licensed nurse documents receipt of the medication by entering the resident ' s name and the medication name, strength, and quantity into a log. (E) A licensed nurse places identification information on the medication or package containing the medication that includes the medical care provider ' s name; the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider ' s order. Facility staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches the information on the medical care provider ' s order. (F) A licensed nurse informs the resident or the resident ' s legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies. The resident ' s clinical record shall contain documentation that the resident or the resident ' s legal representative has received the information and	S3214		

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S3214	Continued From page 15 accepted the risk of potential adverse consequences. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(4)(D)(E) The facility reported a census of thirty-six residents (R). The sample included three residents and five focused record reviews. Based on observation, interview and record review the executive director failed to ensure one (R11) of one resident that received sample medications included the following: 1. License Nurse document receipt of medication with appropriate information into a log; 2. Licensed Nurse failed to included required information on each box/container and indicate verification of such information. Findings included: - Review of R11's medical record revealed she moved into the facility on 05/01/22 with diagnosis of overactive bladder. R11's "Functional Capacity Screen" dated 06/30/23 revealed the resident required physical assistance in the management of her medications. Observation on 10/19/23 at 05:31 PM Certified Medication Aide F unlocked the medication cart which revealed a box of Myrbetriq 25 milligrams (mg) for R11 that had one tablet remaining in the foil package. The box had R11's name on it but did not include the medical care providers name,	S3214		

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S3214	Continued From page 16 dosage to take, route, frequency of administration, and any cautionary instructions. Certified Medication Aide F unlocked the medication room and in the cabinet were more sample containers of Myrbetriq for R11. There were 2 containers with four boxes of Myrbetriq and another three boxes on the shelf. Some of the boxes had the resident's name on them but none included all of the required information and there was no log that included the receipt of the medication. On 10/19/23 at 05:40 PM Administrative Licensed Nurse B acknowledged there was not a log for R11 and the receipt of her Myrbetriq or that each box contained the required information and verification of such information. Review of the undated "Sample and Indigent Medication Policy and Procedure" included the following: A licensed nurse must document receipt of the medication by entering the resident ' s name, the medication name, strength and quantity into a log. Two facility staff members consisting of 2 licensed nurses, or a licensed nurse and medication aide shall verify that the information on the medication or package matches the information on the medical care provider ' s order. Medications from physician-dispensed medication containers can be administered only if packaged and labeled with the following information: Patients full name, date dispensed, physicians name, address, and phone number, name, strength, and quantity of the medication	S3214		

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S3214	Continued From page 17 (unless part of manufacturer¡¦s label), and the directions for use. The Executive director failed to ensure the required information regarding the administration of sample medications for R11 was written on each box and failed to have the appropriate information regarding the acceptance of the medication in the facility.	S3214		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in 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	S3215		

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S3215	Continued From page 18 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) The facility reported a census of thirty-six residents. Based on observation and interview, the executive director failed to ensure staff stored medications according to manufacturer's recommendations related to medication to be stored at room temperature and not refrigeration. Findings included: - During initial tour on 10/19/23 at 07:03 AM Certified Medication Aide C unlocked the medication room for inspection. The medication refrigerator contained two locked boxes, and each contained a bottle of liquid Morphine. On 10/19/23 at 07:15 AM Certified Medication Aide D reported the Morphine is kept in the refrigerator unless Hospice tells us not to. Review of the Morphine Sulfate Solution packet insert read "Store Morphine Sulfate Oral Solution at room temperature 68 degrees F (Fahrenheit) to 77 Degrees F". On 10/19/23 at 07:25 AM Administrative Staff B	S3215		

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S3215	Continued From page 19 read package insert directions online and acknowledged the directions indicated it should not be refrigerated. On 10/23/23 at 01:34 PM Administrative Staff E reported staff are to follow the regulations for medication storage. The executive director failed to ensure staff stored liquid Morphine Sulfate within a specific temperature range in accordance with manufacturer's recommendations.	S3215		
S3261 SS=D	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 thirty-six residents (R). The sample included three residents and five focused record reviews. Based on interview and record review the executive director failed to ensure one (R6) of five focused record reviews contained documentation of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken.	S3261		

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Findings included:

- Review of R6's electronic medical record revealed he moved into the facility on 07/01/21 with diagnosis anoxic brain damage.

On 10/19/23 at 07:35 AM Administrative Licensed Nurse A reported the "Functional Capacity Screen" and the "Negotiated Service Agreement" (FCS/NSA) are one document and the service plan in the electronic record is the health care service plan.

R4's FCS/NSA dated 03/29/23 identified the resident had cognitive impairment and wandering. It did not identify the resident had any socially inappropriate disruptive behaviors or services related to behaviors.

Review of R6's electronic record included the following medical provider documentation and nursing progress notes:
Nursing progress notes from 07/01/22 to 09/27/22 lacked documentation related to any inappropriate sexual behaviors.

On 09/27/22 -medical providers progress note revealed resident seen at staff request for possible UTI " as well as inappropriate behaviors including exposing and manipulating self in front living room area."

Nursing progress ntoes from 09/27/23 lacked documentation realted to any inappropriate sexual behaviors.

On 10/11/22 --medical providers progress note revealed resident seen at staff request for

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S3261	Continued From page 21 ..."continued inappropriate behaviors including exposing and manipulating self in front living room area". Plan for "hypersexual behaviors/GERD (gastroesophageal reflux disease) add Tagemet 200 mg BID (twice a day)". Nursing progress ntoes from 10/11/22 to 10/25/22 the resident record lacked follow up as to the effectiveness of Tagamet related to the resident's hypersexuality. On 10/25/22 --medical providers progress note revealed resident seen at staff request for "continued inappropriate behaviors. Patient had been found previous night in his bedroom fully unclothed with a female resident who was also disrobed. Staff report continued inappropriate sexual comments as well as sexual behaviors. Reporting behaviors to be worse with specific staff members who the patient seems to like." Nursing progress notes from 10/25/22 to 11/13/22 lacked documentation related to the resident having inappropriate sexual behaviors or effectiveness of medication changes. Nursing progress note dated 11/14/23 notes on 10/24/22 at 11:44 PM staff observed R6 and a female resident in R6's bed together completely unclothed. On 11/22/22 --medical providers progress note revealed resident seen at staff request for "continued inappropriate behaviors. Patient had been manipulating himself in living room in front of others and found in private rooms fully unclothed with a female resident who was also	S3261		

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S3261	Continued From page 22 disrobed. Staff report continued inappropriate sexual comments as well as sexual behaviors". Plan "hypersexual behaviors/GERD - increase Tagemet to 400 mg BID." The record lacked any further follow up on the resident's inappropriate sexual behaviors or the effectiveness of medications. An interview on 10/19/23 at 06:11 AM Certified Medication Aide (CMA) I reported the resident had violent tendencies and would corner staff and say inappropriate things. He also had a sexual relationship with a resident and would wave her over to him and then they would go down to his room. On 10/23/23 at 01:03 PM Administrative Licensed Nurse E reorted she would have expected the residents record to include documentation of his behaviors and effectiveness of medication changes related to those behaviors.	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 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;	S3280		

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S3280	Continued From page 23 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) The facility reported a census of thirty-six residents. Based on record review and interview for all residents and all employees, the executive director failed to ensure disaster and emergency preparedness by ensuring performance of quarterly reviews of the facility's emergency management plan with all residents and employees. Findings included: - On 10/19/23 at at 01:35 PM Administrative Staff A provided paper records for reviewing the emergency management plan with residents and with facility staff. Review of the provided information included the following: For residents, Administrative Staff A provided a list of all current residents and documentation that disaster information is reviewed upon admission to the facility. For residents and employees, the information included a typed paper with the following dates: 01/31/23, 04/30/23, 07/31/23 and category of	S3280		

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S3280	Continued From page 24 "Disaster and Emergency Preparedness". The attached "Task Description" noted "Meet with staff and residents to go over fire drills and bad weather policies". This was on three of the meetings and the fourth description was to "Develop and maintain emergency preparedness plan (written emergency plan)". The information lacked a signature page for employees to show that all employes reviewed the information and lacked information as to what residents the information was reviewed with. The information also lacked review of flood, explosion, natural gas leak, lack of electrical or water service and review of what to do in case of a missing resident. On 10/19/23 at 01:35 PM Administrative Staff A acknowledged the information she had did not include evidence of who the reviews were done with or that the whole emergency management plan was reviewed. The executive director failed to ensure the facility's emergency management plan which included all eight required possible emergencies was reviewed with all residents and employees quarterly.	S3280		
S3296 SS=F	26-41-206 (c) (1) Dietary Services Weekly Menu (c) (1) Menu plans shall be available to each resident on at least a weekly basis. This REQUIREMENT is not met as evidenced	S3296		

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S3296	Continued From page 25 by: KAR 26-41-206(c)(1) The facility reported a census of thirty-six residents. Based on observation and interview the executive director failed to ensure the menu plans were available to each resident on at least a weekly basis. This had the potential to affect all residents who lived in the facility. Findings included: - During initial tour on 10/19/23 at 09:50 AM surveyor did not observe a weekly menu posted in the front living area or in the dining room for resident availability. On 10/19/23 at 09:55 AM dietary staff G acknowledged the weekly menu was not posted for resident availability but was working on enlarging one for easier reading. The executive director failed to ensure the menu was available for each residents on at least a weekly basis.	S3296		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes,	S3298		

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fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used.
(3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-206(d)

The facility reported a census of thirty-six residents. Based on observation, interview, and record review the executive director failed to ensure dietary staff prepared and served food at the proper temperature.

Findings included:

- During the initial kitchen tour on 10/19/23 at 06:40 AM Dietary Staff G provided surveyor a notebook with food temperatures in it and reported dietary staff were supposed to be checking the temperature of all foods to ensure they were cooked and served at the proper temperatures. Dietary Staff G also reported for the residents who live on the Memory Care Unit, food is taken down on a small portable steam table and staff serve the residents directly from the steam table.

Review of the food temperature logs for October lacked evidence of staff taking temperatures for the lunch and supper meals on 10/15/23 and

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S3298	Continued From page 27 10/16/23. Observation on 10/19/23 at 11:19 AM in the Memory Care (MC) unit two styrofoam trays sat on the counter with an uncovered bowl of jello sitting on the top tray. The food trays remained on the counter until 11:52 AM, without refrigeration or monitoring of food temperature, more than thirty-three minutes. On 10/19/23 at 11:52 AM Certified Medication Aide (CMA) H reported staff on the MC unit did not take the temperatures of the food after the kitchen brought it down to the unit. She reported one of the food trays sitting on the counter belonged to her and one for a resident. CMA H reported she was not sure how long the trays had been sitting out on the counter. At that point, CMA H took the Styrofoam tray to R3's room without taking the temperature of the food, and sat it on the table. Staff then proceeded to help the resident out of the bed and walked the resident over to the table. Surveyor asked CMA H if there was a way for her to heat up the food and she said she would put it in the microwave. CMA H then picked up the tray and walked with the resident down to the dining room and put the tray in the microwave. Surveyor intervened and stopped the microwave and explained food holding temperatures and need to make sure food remained at a safe temperature to eat and requested she take the temperature of the food. CMA called down to the Kitchen at 12:01 PM and asked them to bring a thermometer to check the temperature of the food. At 12:08 PM, dietary staff G took the temperature of the food in the styrofoam tray, and it read 97 degrees Fahrenheit (F) and stated it was not appropriate	S3298		

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to serve to the resident. He then checked the temperature of the food in the steam table, and it was only 130 degrees F and said he would have to bring the resident something different to eat. Dietary staff G stated the MC staff were supposed to keep the steam table plugged in and serve food directly from the steam table and not make Styrofoam trays for later.

Observations on 10/19/23 of room trays being delivered revealed unidentified staff taking a cart with multiple styrofoam trays to different resident rooms. During the process staff would knock on the resident's door and if it was locked, she had to call for someone to bring her a key to unlock the resident's room. Surveyor observed staff stand at two different resident's room while waiting for someone to come and unlock the door. At 08:25 AM, the same staff stood beside a resident's room and asked Administrative Staff A if she could get her a key for (#) room because she had been waiting for 10 minutes for someone to bring her a key so that she could deliver the resident their food.

During the survey, surveyor conducted confidential resident interviews which revealed the following:
- Resident reported the food us usually cold and sometimes not worth eating.
- Resident reported the food is like any other institutional food and not served very hot.
- Resident reported the food is not always hot enough but they could heat it up in the microwave if needed.
- Resident reported the food is only warm by the time they are served.
- Resident reported that sometimes the food is

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(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
S3298	Continued From page 29 hot and other times what is supposed to be hot is cold. Review of the 2017 "Focus on Food Safety" guidance revealed that holding times and temperature is critical with a "danger zone" from 41 degrees F to 135 degrees F in which rapid growth can occurs. It included a minimum hot holding temperature of 135 degrees F and maximum cold holding temperature of 41 degrees F. The executive director failed to ensure dietary staff monitored food cooking and serving temperatures to ensure it was prepared and served at the proper temperature.	S3298		
S9999	Final Observations Kansas Statute 39-981. Authorized electronic monitoring; reasonable accommodations; notice; consent; use as evidence; prohibitions. (i) Each adult care home shall post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents. This requirement is not met as evidenced by: Scope and Severity of F. The facility reported a census of thirty-six residents (R). Based on observation, record	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087059	A. BUILDING: _____ B. WING _____	10/23/2023

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S9999	Continued From page 30	S9999		

review, and interview, the executive director failed to ensure designated staff posted the required notification at the entrance to the assisted living and at the entrance of each resident's room stating that the rooms of some residents may be monitored electronically.

Findings included:

- During initial tour on 10/19/23 at 05:15 AM upon entrance to the facility the foyer and loby area did not have a posting related to electronic monitoring in the facility. As surveyor proceeded to complete the initial tour observations revealed several, but no all, resident doors had a sign on them which read, "Some resident rooms may be electronically monitored and recorded by and on behalf of the resident(s)." A total of 18 rooms did not have the required posting.

Interview on 10/19/23 at 03:25 PM Administrative Staff A reported there were two residents who had Authorized Electronic Monitoring devices in their rooms.

On 12/19/23 at 01:55 PM Administrative staff A stated she knew the posting needed to be outside of the resident's room entrance but did not know it needed to be posted at each resident's room and at the main entrance to the facility.

The executive director failed to post a notice at the entrance of the facility and at the entrance to each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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