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	N087087	A. BUILDING: _____ B. WING _____	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOVE ESTATES MEMORY HAVEN	1500 S 183RD ST W GODDARD, KS 67052

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaint investigation #162039 for the above named Assisted Living facility conducted on 12/05, 12/06 and 12/07/2022.	S 000		
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: (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) The facility reported a census of 13 residents (R). The sample included three residents and one focused record review. Based on record review and interview, the executive director failed to ensure designated staff completed the	S3085		

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

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Negotiated Service Agreement/Health Care Service Plan for three (R3, R4, R5) 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 and the provider of each service.

Findings included:

- Review of R3's medical record revealed she moved into the facility on 09/08/21 with diagnoses of dementia.

R3's "Functional Capacity Screen" (FCS) dated 10/12/22 identified the resident had impaired cognition, and impaired decision making ability. It also identified the resident required physical assistance of staff with walking/mobility.

R3's "Negotiated Service Agreement/Health Care Service Plan" (NSA/HCSP) dated 10/12/22 identified the resident had short term memory problems, memory recall problems and problems with decision making ability but did not address health care services related to the identified problems.

On 12/06/22 at 10:20 AM "Certified Nurse Aide" F reported staff gave her a couple of choices on clothing to wear, they had to help her get dressed. She had special weighted silverware she used and staff cued and reminded her, but sometimes had to feed her.

On 12/7/22 at 12:51 PM "Administrative Nurse" A acknowledged if a problem is identified on the FCS it needed to be addressed on the

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S3085	Continued From page 2 NSA/HCSP as to what services were being provided for the problem. The executive director failed to ensure designated staff developed a NSA/HCSP to address all identified service needs according the R3's FCS. - Review of R4's electronic medical record revealed she moved into the facility on 02/22/21 with a diagnosis of dementia. R4's annual "Functional Capacity Screen" (FCS) dated 02/22/22 identified the resident needed physical assistance with eating, bathing, dressing, and transfers and was unable to perform toileting and walking/mobility. She also had impaired cognition, impaired vision and impaired decision making ability. R4's "Negotiated Service Agreement/Health Care Service Plan" (NSA/HCSP) dated 02/22/22 failed to identify services for impaired cognition, impaired vision and impaired decision making ability. On 12/06/22 at 10:15 AM "Certified Nurse Aide" F reported staff offered her different clothing to wear and she would nod if she wanted to wear something. We had to help her eat and when she tried to eat on her own we had to cue and remind her to eat. On 12/7/22 at 12:51 PM "Administrative Nurse" A acknowledged if a problem is identified on the FCS it needed to be addressed on the NSA/HCSP as to what services were being provided for the problem.	S3085		

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The executive director failed to ensure designated staff developed a NSA/HCSP to address all identified service needs according the R3's FCS.

- Review of R5's medical record revealed she moved into the facility on 04/28/21 with diagnosis of Parkinson's.

Review of R5's "Functional Capacity Screen" (FCS) dated 09/30/22 identified the resident had impaired cognition, was sometimes understandable and had impaired decision making ability.

R5's "Negotiated Service Agreement/Health Care Service Plan" (NSA/HCSP) dated 09/30/22 failed to include services related to cognitive impairment, inability to understand others at times and impaired decision making ability.

On 12/06/22 at 10:24 AM "Certified Nurse Aide" F reported in the mornings we have to aks the resident if she is ready to get up as she liked to sleep late at times. She liked to wear jewerly and look nice so we offered her choices on what jewelry and clothing she wanted to wear.

On 12/7/22 at 12:51 PM "Administrative Nurse" A acknowledged if a problem is identified on the FCS it needed to be addressed on the NSA/HCSP as to what services were being provided for the problem.

The executive director failed to ensure designated staff developed a NSA/HCSP to address all identified service needs according

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S3085	Continued From page 4 the R3's FCS.	S3085		
S3171 SS=H	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The facility reported a census of 13 residents (R). The sample included 3 residents and 1 closed record review. Based on observation, interview, and record review, the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services for 2 (R4 and R5) of three sampled residents who had unplanned weight loss and failed to notify the medical provider of each resident's weight loss in a timely manner in accordance with acceptable standards of practice. Findings included: - Review of R4's electronic medical record revealed she moved into the facility on 02/22/21 with a diagnosis of dementia. R4's admission "Functional Capacity Screen" (FCS) dated 02/22/21 identified the resident was independent with eating, required physical assistance with all other activities of daily living,	S3171		

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had a total cognitive score of 4, indicating impaired short and long-term memory, impaired memory recall, and impaired decision-making ability.

R4's annual FCS dated 02/22/22 identified the resident needed physical assistance with eating, bathing, dressing, and transfers and was unable to perform toileting and walking/mobility. Her cognitive score remained a 4 (impaired). She also had socially inappropriate disruptive behaviors. The FCS also identified the resident disliked eggs for breakfast and preferred yogurt/fruit or toast with peanut butter.

R4's admission "Negotiated Service Agreement/Health Care Service Plan" (NSA/HCSP) dated 02/22/21 identified the resident was independent with eating, and staff would provide three meals per day. It identified the resident had cognitive impairment but lacked interventions to help R4 with daily decision making and memory impairment. It also identified the resident did not like eggs, and for breakfast she preferred toast with peanut butter, yogurt, or fruit.

R4's significant change NSA/HCSP dated 04/20/21 included the above information and added resident would receive Hospice services from a local agency. It did not include services related to nutritional status/or potential for weight loss.

R4's current NSA/HCSP dated 02/22/22 identified the resident was on a mechanical soft diet and required physical assistance of 1 nursing staff for eating and remained on Hospice

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services. It did not include interventions related to cognitive deficit, impaired decision making, or for staff to provide nutritional supplement shakes with each meal.

Review of the resident's electronic medical record included a medical provider's order dated 02/23/21 to obtain monthly weights.

R4's electronic record included an admission weight on 02/22/21 of 160.6 pounds. The next weight staff obtained was not until 02/04/22 when she weighed 104.8 pounds (a loss of 55.8 pounds, a 35% weight loss). Staff weighed the resident again on 10/04/22 and she weighed 98.2 pounds (a loss of an additional 6.6 pounds). According to her electronic record, R4 lost 62.4 pounds between 02/22/21 and 10/04/22, a 38.85% total weight loss.

R4's record also had an order dated 05/26/21 for staff to provide the resident "Ensure" or "Boost" nutritional shakes with each meal. Review of her "Medication Administration Record" from May 2021 to December 2021, revealed recorded shakes were given as ordered, however it did not record the percentage of shake intake.

In January 2022 staff documented 21 times they did not give her shakes as ordered due to her eating her meal or "due to condition".

In February 2022 staff documented 26 times they did not give the shakes as ordered, five times for refusal and 21 times not administered "due to condition".

In March of 2022 staff documented 16 times they

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did not give the shakes as ordered 13 times "due to condition", twice because shake not available and 1 time the resident refused.

In April 2022 staff documented 17 times they did not give the shakes as ordered 10 times because it was not available, and the rest were documented as she either "refused" or not administered "due to condition".

Review of the MARs from May 2022 to July 2022 revealed staff provided the resident the shakes as ordered unless she refused. From August 2022 to December 2022 staff gave the resident her shakes as ordered.

The record lacked evidence the licensed nurse notified the medical provider that certified medication aides held the nutritional supplement shakes "due to condition" of the resident or because she ate her meal. The record lacked a medical provider's order to hold the shakes if the resident ate her meal or depending on her "condition".

R4's progress notes from 02/23/21 to 12/05/22 included the following documentation related to nutritional status:

02/26/21 - Resident appears to be very shaky, during meals, resident tends to struggle keeping food on silverware. Resident may benefit from having weighted silverware and perhaps a weighted cup.
02/27/21 - The resident had tremors, which hindered her ability to manage her own eating.
05/26/21 - New orders to add "Ensure" or "Boost" to meals.

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07/21/21 - Resident in more pain, very stiff, and more lethargic.
12/17/21 - Resident evaluated by Speech Therapy to clarify diet and is cleared to have mechanical soft with thin liquids.
12/22/21 - Hospice to readdress the resident's need to remain in bed or if staff can get her up due to increase in intake and cognition.
07/12/22 - Resident getting up twice a day and feeding self at table.
07/21/22 - Resident feeds self well in room, will monitor.
08/10/22 - New orders for regular diet due to resident does not like ground meat.
09/01/22 - Resident able to feed self on regular diet, does not enjoy eating with others as it tends to agitate her.
09/07/22 - Resident ate 100% yesterday and only 25 % of breakfast today.
10/24/22 - Resident eating with hands and not using silverware, will inquire about finger foods.
11/15/22 - Resident eats with fingers instead of silverware.
12/05/22 - Resident intake has declined, refuses to be fed most of the time and sleeping more. Resident offered shake three times a day but will not drink at times.

Review of the nursing progress notes, and physician's orders lacked evidence the licensed nurse notified the physician the resident was bedfast and could not be weighed and lacked physician notification about concerns related to continued weight loss and poor nutritional status.

Observation on 12/05/22 at 04:55 PM Certified Medication Aide D and Certified Nurse Aide E helped the resident to get up for supper. As staff

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dressed the resident in bed it appeared that she had lost weight, as her slacks were too big. Staff used a mechanical lift to raise her out of bed and sit her in the wheelchair and pushed her down to the dining room for supper.

On 12/06/22 at 08:29 AM staff served the resident French Toast and sausage cut into pieces for breakfast. She also had 2 cups with lids, one, a nutritional shake which staff assisted her to drink, and a cup of water. After sitting by herself for a while, staff sat beside her and assisted her to finish eating.

On 12/06/22 at 01:24 PM "Certified Nurse Aide" (CNA) F reported, when the resident came initially, she would walk around independently and wanted to go home. There was a period of time when the resident quit walking or standing and was bed fast. Staff gave her shakes and food in bed, but she would not eat. CNA F confirmed staff did not keep track of how much a resident ate but would let the nurse know if they did not eat.

During a confidential interview, unidentified staff reported there was a period of time the resident was bed fast, and staff could not weigh her. Staff gave her a lot of shakes instead of food. When staff did give her food, they did not always feed her.

During a confidential interview, unidentified staff reported she had been told by another staff the resident did not ever get out of bed and staff did not feed her, but no one knew why. So, she and another staff member would help her eat pudding and soups when she was in bed.

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During another confidential interview staff reported the resident originally walked independently and would exit seek wanting to go home. She went to the behavior health unit and became bed fast shortly after she got back. Staff did not really feed her food in bed and gave her the "Ensure" (nutritional supplement drink) instead. After Licensed Nurse C started, staff began getting her up and she was eating again and doing a lot better.

On 12/06/22 at 01:55 PM Administrative Nurse B acknowledged if a resident had an order to be weighed monthly, staff should weigh them monthly. If a resident could not sit on the chair scale the only way staff could weigh a resident would be to take them to the other building and weigh them on the wheelchair scale. She also confirmed the staff did not keep track of how much the residents ate at meals or how much of the supplement shakes residents consumed.

On 12/09/22 at 10:52 AM via electronic interview Administrative Nurse B acknowledged staff held the resident's supplemental shakes and did not notify the physician.

The operator failed to ensure staff followed a medical provider's order to obtain monthly weights, failed to provide nutritional supplement shakes three times per day with meals, failed to monitor resident intake when at risk for weight loss and failed to notify the physician when the resident became bedbound, and staff were unable to weigh her. They further failed to notify the physician when the resident stopped eating and had a significant change in condition. Staff

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also failed to notify the medical provider when they were not able to weigh the resident or when the CMAs chose not to give the resident her shakes "due to condition".

- Review of R5's medical record revealed she moved into the facility on 04/28/21 with diagnosis of Parkinson's.

Review of R5's "Functional Capacity Screen" (FCS) dated 04/28/22 identified the resident required supervision with eating and had impaired cognition. Staff completed a significant change FCS on 09/30/22, which indicated the resident needed physical assistance with eating.

R5's "Negotiated Service Agreement/Health Care Service Plan" (NSA/HCSP) dated 09/30/22 identified staff would provide physical assistance with eating, use adaptive silverware, and provide a mechanical soft diet. The NSA/HCSP did not include any specifics as to foods resident liked, nutritional supplements or other interventions related to weight loss and nutritional status. The facility failed to revise the resident's NSA/HCSP when the resident initially had unplanned weight loss and to failed to update interventions for weight loss.

Review of the resident's weights included the following:
07/01/21 - 206.2 pounds
08/2021 - No weight in record.
09/01/21 - 202 pounds
10/2021 - No weight in record.
11/10/21 - 189 pounds
12/01/21 - 190.6 pounds, a loss of 11 pounds in three months. The resident record lacked

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evidence the medical provider was notified of the resident's weight loss.
01/02/22 - 187 pounds
02/04/22 - 175 pounds
03/15/22 - 172 pounds, a loss of 18.6 more pounds in three months. The record lacked evidence the facility notified the medical provider of the resident's continued weight loss.
04/06/22 - 186 pounds
04/30/22 - 177.2 pounds
05/2022 - No weight in record.
06/01/22 - 161.8 pounds
07/05/22 - 160.6 pounds, another 11.4 pounds in since March. The record lacked evidence the facility notified the medical provider of the resident's continued weight loss.
09/02/22 - 152 pounds, eight-pound loss in 2 months.
The resident had a total unplanned weight loss of 50 pounds, 24.25% of her body weight, in 1 year.

The nurse failed to notify the physician of the resident's unplanned weight loss until 08/24/22 and failed to implement nursing/dietary measures to promote adequate nutrition and reduce the risk of continued weight loss.

On 09/28/22 the physician wrote an order for Hospice consult related to decline and weight loss with failure to thrive.

Review of the resident's nursing progress notes from 07/26/21 to 12/06/22 revealed the following nursing documentation regarding nutritional status and weight loss:

11/23/21 - Update the resident's diet to

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mechanical soft with nectar thick liquids due to choking on liquids and food.
12/01/21 - New order for nectar thick liquids/mechanical soft diet.
02/21/22 - Resident returned from Emergency Department visit and did not have much appetite and did not drink much.
05/23/22 - Resident had increased agitation the past week and refused to get out of bed or take medication at times.
06/01/22 - No new orders noted, but medical provider would like to have staff push fluids.
07/20/22 - The resident did not feel well and tested positive for COVID.
08/09/22 - Medical provider notified the resident was lethargic, not as alert as usual, and appetite low. (This is the first provider notification of resident's appetite.)
09/29/22 - Resident evaluated by medical provider for routine follow up and noted weight loss and increased choking with intake. Received new orders for speech evaluation and for Hospice consult. Local Hospice contacted and noted they would meet with family.
10/03/22 - Speech therapy to assess the resident's feeding needs.
10/10/22- Ordered curved silverware with large handles for tremors and occupational therapy to come after silverware here for possible strap to help resident hold silverware to be able to feed self.
11/03/22 - Resident continued to have choking episodes with intake, pockets food at times, and takes a while to eat on own. Staff attempted to feed resident, but resident declines assistance at times. Resident's power of attorney and Hospice aware of status.
11/07/22 - Resident laying in bed with blank

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stare, reaching up to the air. Staff attempted to sit resident up and feed her, but resident not eating.
11/08/22 - Resident up this day for breakfast and ate with assistance.
11/28/22 - Resident refused assistance with feeding and since getting the curved spoon resident did better with eating on her own. Staff would monitor if she continued to refuse help and if she ate. Staff would update care plan.

The nursing progress notes from 07/02/21 to 08/29/22 when the resident had an unplanned weight loss of 45.6 pounds, failed to show the medical provider was notified of the resident's weight loss.

Surveyor requested a list of residents who received nutritional supplement for weight loss and "Licensed Nurse" C included R5 as having a supplement shake as needed (PRN). Review of the resident's medication administration record did not include documentation for a PRN supplement shake.

Observation on 12/06/22 at 02:22 PM revealed R5 sat at the table alone with a specialized bent spoon in her hand and in the bowl and her glass sitting on the table. Surveyor observed resident from 02:22 PM to 02:43. Resident did not take one bite and staff did not come to assist her to eat.

On 12/06/22 at 10:42 AM Certified Nurse Aide (CNA) F acknowledged the resident was losing weight and staff helped her eat. She used to feed herself and most of it ended up on the floor. She had a special spoon she used when she

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S3171	Continued From page 15 wanted to feed herself. On 12/06/22 at 02:53 PM Certified Medication Aide L reported the resident would sometimes feed herself, but most meals staff need to help her. She has special silverware but not sure if that is helping or not. On 12/7/22 at 02:07 PM Licensed Nurse C acknowledged the resident had unplanned weight loss and was started on Hospice services for weight loss and decline in status. She did not know of what interventions facility had done to help the resident maintain nutritional status and decrease weight loss prior to her employment in November of 2021. The administrator failed to ensure a licensed nurse notified the resident's medical provider of resident weight loss, failed to involve the facility's registered dietitian and failed to implement necessary health care services when the resident had a significant unplanned weight loss of 50 pounds in a year.	S3171		
S3200 SS=D	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:	S3200		

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S3200	Continued From page 16 (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. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) The facility reported a census of 13 residents (R). The sample included three residents and one focused record review. Based on record review and interview one (R6) of one focused record review, the executive director failed to ensure all medications were administered in accordance with a medical care provider's written order. Findings included: - R6's electronic medical record revealed she moved into the facility on 10/07/19 with diagnosis of malnutrition and right knee and shoulder pain. R6's "Functional capacity Screen" dated 10/07/20 identified the resident needed physical assistance with management of her medications and medical treatments. R6's "Negotiated Service Agreement/ Health Care Service Plan" dated 10/07/20 identified a Licensed Nurse or Certified Medication would provide physical assistance with management of	S3200		

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S3200	Continued From page 17 her medications and medical treatments. Review of the resident's record included a physician's order dated 01/09/20 for staff to apply Cerave Cream to the resident's whole body daily for dry skin. Review of the resident's "Medication Administration Record / Treatment Records" (MAR/TAR) revealed the Cerave Cream was not put on the MAR/TAR for administration until 07/28/20 and first administered on 07/29/20, 6 months after the facility received the physician's order. On 12/07/22 at 03:39 PM "Administrative Nurse" B looked through the electronic record and identified the Cerave Cream had been entered into the electronic system incorrectly, so it did not show up on the MAR/TAR for certified staff to administer. The executive director failed to ensure all medications were administered as ordered.	S3200		
S3215 SS=F	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed	S3215		

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S3215	Continued From page 18 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)(1) The facility reported a census of 13 residents. Based on observation and interview the executive director failed to ensure all medications and biologicals managed by the facility were kept in a locked medication room, cabinet, or medication cart with only licensed nurses and medications aides having access to the stored medications and biologicals. Findings included:	S3215		

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S3215	Continued From page 19 - Observation on 12/6/22 at 02:22 PM the door to the medication room was open and no staff present in the medication room. This allowed anyone, including visitors who were doing activities with residents, access to medications in the medication room. Surveyor went into the medication room, left the door open and observations revealed the counter in the med room had two large drawers full of overflow medication for residents and another drawer with some medications in it. No staff entered the medication room while surveyor was in it. There were two facility staff and three volunteers in the dining room doing activities with residents. On 12/06/22 at 02:32 PM "Certified Medication Aide" (CMA) L left the dining room to check on a resident and returned at 02:40 PM going into the medication room. Surveyor followed CMA L who stated the door is probably supposed to be shut when no staff are in the room. On 12/08/22 at 04:57 PM "Administrative Nurse" B confirmed the medication room is to be shut and locked when staff are not in the room. The administrator failed to ensure a licensed nurse dated the Tubersol to ensure it was not used beyond the manufacturer's recommended date of expiration once the vial had been opened and entered.	S3215		
S3240 SS=F	26-41-103 (c) Staff Development on Dementia (c) If the facility admits residents with dementia, the administrator or operator shall ensure the	S3240		

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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:
KAR 26-41-103 (c)

The memory care facility reported a census of 13 residents and identified 12 of those residents had cognitive impairment. The sample include three residents and 1 closed record review. Based on interview and record review for three of four direct care staff, the executive director failed to ensure the provision of staff orientation and in-service education on the treatment and appropriate responses to persons who may exhibit behaviors associated with dementia.

On 12/07/22 at 02:18 PM "Administrative Nurse" B provided dementia training for CMA G who had a hire date of 08/25/21 but the training was not completed until 10/13/21, 2 months after hire date. She was not able to provide orientation on dementia training for "Licensed Nurse" C, "Certified Medication Aide" J and "Certified Nurse Aide" N.

On 12/07/22 at 02:18 PM "Administrative Nurse" B reported for dementia training they had in-services annually and upon hire and have a DVD that staff are supposed to watch. There were problems with getting staff to be able to watch the DVD for orientation so now the information is on a thumb drive that they can take

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S3240	Continued From page 21 and watch during their orientation period. The executive director failed to ensure the provision of staff orientation and in-service education on the treatment and appropriate responses to residents regarding dementia training.	S3240		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide.	S3248		

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S3248	Continued From page 22 This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(1) The facility reported a census of 13 residents. Based on record review of five newly hired employees, the executive director failed to have evidence of licensure, registration, and certification of training for two newly hired staff who required specialized education and training verified upon hire. The findings included: - On 12/06/22, review of the five selected employee records provided by "Administrative Staff" A, revealed the following concerns: - "Licensed Nurse" (LN) ,C hired on 11/01/21 did not have her licensure checked until 11/08/21. - "Certified Medication Aide" (CMA) G hired on 08/25/21 did not have her registration/certification checked until 08/31/21. - CMA J hired on 01/17/22 did not have her registration/certification checked until 01/18/22. On 12/6/22 at 09/18/22 "Administrative Staff" A acknowledged designated staff were running a little behind on getting registry and licensure checks completed upon hire. The executive director failed to ensure staff who required specialized education and training were verified to provide health care services upon hire.	S3248		

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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 13 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 actions, and the results of actions taken for three (R3, R4, R5,) of three sampled residents. Findings included: - Review of R3's medical record revealed she moved into the facility on 09/08/21 with diagnoses of dementia. R3's "Functional Capacity Screen" dated 10/12/22 identified the resident needed physical assistance with all activities of daily living including eating, had bladder incontinence, impaired cognition, and at risk for falls/unsteadiness. R3's "Negotiated Service Agreement/Health Care	S3261		

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Service Plan" dated 10/12/22 identified the resident required assistance of one nursing staff for activities of daily living and assistance of two staff for transfers.

Review of R3's nursing progress notes included the following documentation:

12/07/21 - Resident complained of ears feeling full and everything sounded muffled. New orders for Debrox drops to both ears for three days and flush on day four. The record lacked follow up as to the effectiveness of flushing her ears.

01/12/22 - Resident still complained of muffled sounds. No further assessment on ears and concerns with hearing.

03/31/22 - New order for Sertraline (antidepressant) 25 milligrams daily for depression and anxiety. The record lacked follow up as to the effectiveness of the antidepressant.

06/01/22 - New order for Nystatin powder topically for 10 days due to yeast under breast. Staff failed to follow up if the Nystatin was effective.

10/31/22 - Resident had a non injury fall. The record lacked follow up as to status post fall.

11/03/22 - New order for Ativan (for anxiety) twice a day for anxiety/restlessness. The record lacked follow up on effectiveness.

On 12/07/22 at 12:31 PM "Licensed Nurse" (LN) C reported when psychotropic medications are changed there should be a follow up in a couple

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of weeks as to the effectiveness of the medication change and should follow up any time when a resident has a change in condition.

The executive director failed to ensure designated staff documented all incidents and symptoms of illness, what was done, and the results of the action taken for R3 related to follow up after falls and when new medications were initiated.

- Review of R4's electronic medical record revealed she moved into the facility on 02/22/21 with a diagnosis of dementia.

R4's annual FCS dated 02/22/22 identified the resident needed physical assistance with eating, bathing, dressing, and transfers and was unable to perform toileting and walking/mobility. Her cognitive score remained a 4 (impaired). She had socially inappropriate disruptive behaviors. The FCS identified the resident disliked eggs for breakfast and preferred yogurt/fruit or toast with peanut butter.

R4's current NSA/HCSP dated 02/22/22 identified the resident was on a mechanical soft diet and required physical assistance of one nursing staff for eating and remained on Hospice services. It did not include interventions related to her cognitive deficit, impaired decision making, or for staff to provide nutritional supplement shakes with each meal.

Review of R4's nursing progress notes included the following:

02/26/21 - Resident appears to be very shaky,

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during meals resident tends to struggle keeping food on silverware. Resident may benefit from having weighted silverware and perhaps a weighted cup. The record lacked follow up if the staff provided the resident with weighted silverware and if her ability to feed herself improved.

04/20/21 - Resident had a reduction in her Seroquel (an antipsychotic) medication. Record lacked follow-up as to how the decrease effected her behaviors.

04/27/21 - Resident had seizure type activity with vomiting. Her record lacked follow-up if medication caused nausea and for effectiveness of the medication for anxiety/seizures.

05/24/21 - Resident's family requested nectar thickened liquids. Record lacked follow up if the nectar thick liquids improved or changed her fluid intake.

05/26/21 - New orders to add Ensure or Boost to meals per Hospice. Record lacked documentation as to why the resident was started on the supplement, if the resident drank them, or if they had the desired effect.

06/17/21 - Resident with small wound on her bottom. Hospice will dress the wound twice weekly during their visits. Record lacked documentaion of the wound size, drainage, treatment effectiveness, routine monitoring and healing by facility nurse.

12/22/21 - Hospice to readdress resident's need to be bed bound with family due to the resident

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having increased intake and more alertness. Record lacked documentation of date and reason resident became bed bound prior to the 12/22/21 entry, record also lacked documentation of resident needs related to bed bound status.

01/28/22 - Resident rolled out of bed onto her right side. Record lacked follow up as to resident's status post fall.

08/30/22 - Resident reevaluated by hospice due to behavior increased and new orders for Risperdal (an antipsychotic) daily in the AM. The record lacked documentation of the resident's behaviors, what staff did nonpharmacological to reduce behaviors and lacked follow up on the effectiveness on the Risperdal on her "behaviors".

09/01/22 - Resident able to feed self regular diet, but doesn't enjoy eating with others as they tend to agitate her. The record lacked follow up on what was done during meals to decrease agitation for resident and effectiveness of any interventions.

10/24/22 - Resident eating all meals with hands and not utilizing silverware, will inquire about finger foods for resident. The record lacked follow up if the resident was provided finger foods and how if it was helpful.

On 12/07/22 at 12:31 PM "Licensed Nurse" (LN) C reported when psychotropic medications are changed there should be follow up in a couple of weeks as to the effectiveness of the medication change and should follow up on any time when a resident has a change in condition.

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The executive director failed to ensure the licensed nurse included documentation of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken.

- Review of R5's medical record revealed she moved into the facility on 04/28/21 with a diagnosis of Parkinson's.

Review of R5's "Functional Capacity Screen" (FCS) dated 04/28/22 identified the resident required Physical assistance with all activities of living except eating, which she required supervision. A significant change FCS dated 09/30/22, indicated the resident needed physical assistance with eating and was unable to perform all other activities of daily living.

R5's "Negotiated Service Agreement/Health Care Service Plan" (NSA/HCSP) dated 09/30/22 identified staff would provide physical assistance with eating, use adaptive silverware, and provide a mechanical soft diet. Staff would provide assistance of two staff for dressing, toileting, transfers, 1-2 staff with bathing and onef staff for mobility using a wheelchair. The NSA/HCSP lacked interventions for eating including foods resident liked, nutritional supplements or other interventions related to weight loss and nutritional status.

Review of the resident's record revealed on 06/01/21 the resident weighed 211.8 pounds. Six months later on 12/01/21 she weighed 190.6 pounds, revealing an unplanned weight loss of 21.2 pounds. The resident continued to lose

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	N087087	A. BUILDING: _____ B. WING _____	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOVE ESTATES MEMORY HAVEN	1500 S 183RD ST W GODDARD, KS 67052

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S3261	Continued From page 29	S3261		

weight and on 09/02/22 weighed 152 pounds, an additional 38.6 pounds of weight loss.

Review of the resident's nursing progress notes revealed the following documentation:

10/13/21- Resident with orders to continue the nystatin power for groin rash and a new order for Diflucan 150 mg today and may repeat in 3 days if no improvement. Will continue to monitor. The record lacked follow up of rash condition/healing and need for repeat of Diflucan per order.

10/27/21 - (14 days later) Entry recorded to continue the Nystatin powder to groin area.

07/02/21 to 12/01/21 The record lacked any documentation of the resident weight loss and lacked any note of interventions to monitor/reduce risk of further weight loss. On 12/1/21 Speech therapy recommended Nectar thick liquids with mechanical soft diet.
The record lacked documentation if the change in diet improved the resident's dietary intake.

12/07/21 - Family requested something to help resident sleep and got new order for Melatonin (supplement) at bedtime. The record lacked follow up as to the effectiveness of the Melatonin.

02/21/22 - Entry recorded resident did not have much appetite and did not drink much.

08/09/22 - Resident is lethargic and not as alert and appetite is low. The record lacked follow up as to if resident remained lethargic, or had any changes in appetite.

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S3261	Continued From page 30 09/29/22 - Resident evaluated by medical provider and noted weight loss and increased choking with intake. Hospice consult ordered for failure to thrive. From 12/01/21 to 09/02/22 the resident lost an additional 38.6 pounds. The record lacked any documentation regarding weight loss and/or dietary interventions other than changing diet to improve nutritional status. The resident record lacked documentation regarding weight loss, follow up on effectiveness of new medications and changes in condition. On 12/07/22 at 12:31 PM "Licensed Nurse" (LN) C reported when psychotropic medications are changed there should be a follow up in a couple of weeks as to the effectiveness of the medication change and should follow up on any time when a resident has a change in condition. The executive director failed to ensure the licensed nurse included documentation of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken.	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	S3280		

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S3280	Continued From page 31 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) The facility reported a census of 13 residents. Based on record review and interview for all facility residents, 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. Findings include: - On 12/05/22 at 03:30 PM "Administrative Staff" A acknowledged he had not done disaster reviews with residents in memory care because he believed he did not need to, as the residents with dementia would not be able to recall what had been discussed. For all residents in the memory care facility, the executive director failed to ensure the completion of quarterly reviews of the emergency management plan with all residents.	S3280		

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S3310	Continued From page 32	S3310		
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) The facility reported a census of 13 residents(R). The sample included three residents and one closed record review. Based on interview and record review for three sampled residents (R3, R4, and R5), and two of five newly hired staff, the administrator 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. Findings included: - Review of R3's electronic medical record revealed she moved into the facility on 09/08/21.	S3310		

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S3310	Continued From page 33 The electronic medical record revealed the resident did not receive a TB symptom screen or her TB two-step skin test until 10/12/21, more than 7 days after admission. - Review of R4's electronic medical record revealed she moved into the facility on 02/22/21. The electronic medical record revealed the resident did not receive a TB symptom screen or her TB two-step skin test until 03/26/21, more than 7 days after admission. - Review of R5's electronic medical record revealed she moved into the facility on 04/28/21. The record failed to include a TB two-step TB skin test. On 12/7/22 at 01:01 PM Administrative staff A acknowledged TB symptom screens and TB skin testing are to be initiated within the first seven days of employment. Review of the "Tuberculosis (TB) Guidelines for Adult Care Homes" dated June 2013 revealed each new resident shall have an initial TB symptom screen that includes the components of the TB symptom screen questionnaire within seven days of residency. Each new resident shall receive a two-step skin test within seven days of residency. The administrator failed to ensure designated staff completed TB symptom screens and skin testing according to TB guidelines. - Review of five newly hired employees revealed the following:	S3310		

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S3310	Continued From page 34 Licensed Nurse C hired on 11/01/21, record lacked a symptom screen in her employee file and lacked TB skin testing until 06/21/22. Dietary staff M hired on 06/11/21 record lacked a TB symptom screen until 06/11/22 and her two-step TB skin test not initiated until 06/28/22. On 12/06/22 at 08:58 AM administrative staff A acknowledged the facility had completed an audit for TB monitoring and identified some had not been completed. Review of the "Tuberculosis (TB) Guidelines for Adult Care Homes" dated June 2013 revealed each new resident shall have an initial TB symptom screen that includes the components of the TB symptom screen questionnaire within seven days of residency. Each new resident shall receive a two-step skin test within seven days of residency. The administrator failed to ensure designated staff completed TB symptom screen and skin testing according to TB guidelines.	S3310		