STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046056	A. BUILDING: _____ B. WING _____	11/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE HEARTLAND ASSISTED LIVING	16207 MIDLAND DRIVE SHAWNEE, KS 66217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaint investigations 122012, 122403, and 122404 at the above named assisted living facility conducted on 10-30-17, 10-31-17, 11-1-17, 11-6-17 and 11-7-17.	S 000		
S3026 SS=D	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(A) The facility reported a census of 41 residents. The sample included 3 residents, one focus review resident and one closed record review. Based on record review and interview for 1 (#400) of 1 closed record review resident, the operator failed to ensure a cognitively impaired resident was not subjected to abuse when facility staff restrained the resident by placing a lap buddy cushion on the resident's wheelchair which limited the resident's movement. Findings included: - Record review for resident #400 revealed admission on 8-11-15 with diagnoses Atrial	S3026		

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

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S3026	Continued From page 1 Fibrillation, Osteoporosis, and Cerebellar Hemorrhagic Stroke. The Functional Capacity Screen (FCS) dated 7-13-16 revealed resident required physical assistance with bathing, dressing, toileting, transfers and walking/mobility; supervision with eating; and unable to perform management of medication and treatments. Incontinent of bladder. Cognition: problems with short and long term memory. memory recall and decision-making. Current problems/risks identified included falls/unsteadiness. Resident used wheelchair. The Negotiated Service Agreement (NSA) dated 7-13-16 recorded resident received services for "full body" assistance with bathing and dressing. Assistance of one staff with toileting, transfers and mobility per wheelchair. Facility staff to administer medications as ordered. Note: The NSA lacked documentation of use of a lap buddy to prevent falls. Physician order dated 5-13-17: Please use lap buddy to keep from falling from chair. Staff Communication Notes for day and evening shift stated: "(Resident #400) is to be watched and if a State Surveyor or Ombudsman enters the facility, resident's lap tray is to be quickly (and quietly) removed and placed in resident's apartment." Observation on 11-1-17 at 9:55 am of Resident #120 revealed resident sitting in a wheelchair. Two certified staff pushed resident to room to transfer into recliner. Gait belt applied and two staff performed the transfer with some difficulty as resident bears weight poorly and holds onto	S3026		

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S3026	Continued From page 2	S3026		

wheelchair. Observed lap buddy cushion in resident's closet.

Interview on 11-1-17 at 10:00 am revealed resident oriented to person. Resident stated he/she "came to facility in April of 1915". Was able to state that if he/she required assistance, "I push the button then yell." Resident rambled in conversation between past and present. Limited ability to make needs known.

Interview on 11-1-17 at 10:13 am with Certified Staff N demonstrated how lap buddy cushion fit on wheelchair and confirmed resident had used it since May. Further confirmed he/she had been instructed to remove if a surveyor comes in. Stated he/she "knows it's a restraint" and "doesn't use it all the time."

Interview on 11-1-17 at 10:19 am with Administrative Nurse B stated resident's (family member) requested to use the device, purchased it and brought it to the facility. Stated facility staff informed resident's family member the cushion was considered to be a restraint but family very insistent on using it.

Interviews on 11-1-17 at 12:00 pm with operator, Administrative Staff C and Administrative Nurse B stated they realized lap tray was a restraint, and had each told the resident's family member no, but he/she was insistent. It's put on while family is here and taken off and put in the closet when family leaves.

For Resident #400, the operator failed to ensure the cognitively impaired resident was not subjected to abuse when facility staff restrained the resident by placing a lap buddy cushion on his/her wheelchair which limited the resident's

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S3026	Continued From page 3 movement.	S3026		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(A)	S3028		

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S3028	Continued From page 4 The facility reported a census of 41 residents. The sample included 3 residents, one focus review resident and one closed record review. Based on record review and interview for 1 (#120) of 3 sampled residents, the operator failed to ensure each allegation of neglect shall be reported to the department within 24 hours and investigated when the resident experienced an elopement. Findings included: - Record review for Resident #120 revealed admission on 5-19-17 with diagnoses Diabetes Mellitus Type 2, Dementia and Hypertension. The Functional Capacity Screen (FCS) dated 5-19-17 recorded resident required physical assistance with bathing, dressing, toileting, transfers, and walking/mobility; independent with eating; and unable to perform management of medications and treatments. Frequently incontinent of bladder. Cognition: problems with short term memory circled. Problems with communication: sometimes understandable in expression and ability to understand others. Current problems/risks identified included impaired hearing and impaired decision-making. Resident uses a walker and wheelchair. (Note: Coding for Cognition inaccurate as Administrative Nurse B confirmed not using FCS manual to complete the form). The Negotiated Service Agreement (NSA) dated 5-19-17 recorded services for full body assist with all aspects of bathing and dressing. Assistance of 1 staff with toileting and use of incontinence products. RN (registered nurse)/LPN (licensed practical nurse)/CMA (certified medication aide) will administer all medications per physician	S3028		

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S3028	Continued From page 5	S3028		

orders. Monitoring of fasting blood sugar checks. The NSA indicated resident had "Dementia related issues." The NSA indicated resident was at risk for falls.

Review of Nurse's Notes:
6-7-17 at 8:40 am: "Late entry for 6-6-17 6:40 pm. CMA (Certified Medication Aide) on duty notified this writer that resident was found wandering at the back of the building (facility). Resident stated that he/she was looking for his/her (family member) so that they can go shop for a house. Resident reoriented and brought back in the building. 30 minute checks initiated, (family member) notified and came to visit resident." Signed by Administrative Nurse B.
8-2-17 11:45 am: "Resident noted to be exit seeking on the Northwest door. Resident redirected, fluid offered. Physician and (Family member) notified of the resident's current situation...Resident oriented to surroundings." Signed by Administrative Nurse B.

Interview on 11-1-17 around 11:00 am with Certified Staff O stated he/she was the staff member who found the resident. Stated "when I found him/her , he/she was in the courtyard...in his/her wheelchair." Had gotten out one of the side doors into the courtyard ("where the East and West halls make a U"). We refer to it as "out back". Did not remember the exact time, stated "it was around 1 or 2 pm, right after lunch". Was alerted by another resident that "somebody was out back." Certified Staff O stated Resident #120 wheels self around the halls and is exit seeking. "Sundowners kicks in real early", usually after lunch will start saying he/she needs a ride, asking where the bus stop is and wanting to get hold of his/her spouse (who is deceased). Certified Staff O stated "we keep (Resident #120) in the lobby

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S3028	Continued From page 6 so we can keep eyes on him/her. Interview on 10-31-17 at 1:54 pm with operator confirmed he/she failed to report the elopement to the department and did not perform an investigation. For Resident #120, the operator failed to ensure each allegation of neglect shall be reported to the department within 24 hours and investigated when the resident experienced an elopement.	S3028		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c)(1) The facility reported a census of 41 residents. The sample included 3 residents, one focus review resident and one closed record review. Based on record review and interview for 1 (#400) of 1 focus review resident, the operator failed to ensure designated facility staff shall conduct a screening to determine each resident's functional capacity at least every 365 days.	S3081		

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S3081	Continued From page 7 Findings included: - Record review for resident #400 revealed admission on 8-11-15 with diagnoses Atrial Fibrillation, Osteoporosis, and Cerebellar Hemorrhagic Stroke. The Functional Capacity Screen (FCS) dated 7-13-16 revealed resident required physical assistance with bathing, dressing, toileting, transfers and walking/mobility; supervision with eating; and unable to perform management of medication and treatments. Incontinent of bladder. Cognition: problems with short and long term memory. memory recall and decision-making. Current problems/risks identified included falls/unsteadiness. Resident used wheelchair. The record lacked a functional capacity screening completed within the last 365 days. Interview on 11-1-17 at 10:19 am with Administrative Nurse B confirmed the FCS was not performed at least every 365 days. For resident #400, the operator failed to ensure designated facility staff conducted a screening to determine each resident's functional capacity at least every 365 days.	S3081		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every	S3092		

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S3092	Continued From page 8 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(d)(1) The facility reported a census of 41 residents. The sample included 3 residents, one focus review resident and one closed record review. Based on record review and interview for 1 (#400) of 1 focus review resident, the operator failed to ensure the review and, if necessary, revision of the negotiated service agreement at least every 365 days. Findings included: - Record review for resident #400 revealed admission on 8-11-15 with diagnoses Atrial Fibrillation, Osteoporosis, and Cerebellar Hemorrhagic Stroke. The Functional Capacity Screen (FCS) dated 7-13-16 revealed resident required physical assistance with bathing, dressing, toileting, transfers and walking/mobility; supervision with eating; and unable to perform management of medication and treatments. Incontinent of bladder. Cognition: problems with short and long	S3092		

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S3092	Continued From page 9 term memory. memory recall and decision-making. Current problems/risks identified included falls/unsteadiness. Resident used wheelchair. The Negotiated Service Agreement (NSA) dated 7-13-16 recorded resident received services for "full body" assistance with bathing and dressing. Assistance of one staff with toileting, transfers and mobility per wheelchair. Facility staff to administer medications as ordered. On bottom of last page of NSA was the following statement: "7-13-16 noted that this resident's NSA was not completed by previous director of nursing at last date of review scheduled. FCS done 9-2-15 but no NSA found." The record lacked documentation of a NSA completed within the last 365 days. Interview on 11-1-17 at 10:19 am with Administrative Nurse B confirmed the record lacked documentation of an NSA review in 2017. For resident #400, the operator failed to ensure the review and, if necessary, revision of the negotiated service agreement at least every 365 days.	S3092		
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 10	S3155		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-204(a)

The facility reported a census of 41 residents. The sample included 3 residents, one focus review resident and one closed record review. Based on observation, record review and interview for 1 (#120) of 3 sampled residents, the operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident and were in accordance with the functional capacity screening and the negotiated service agreement to address the cognitively impaired resident's risk for elopement and falls.

Findings included:

- Record review for Resident #120 revealed admission on 5-19-17 with diagnoses Diabetes Mellitus Type 2, Dementia and Hypertension.

The Functional Capacity Screen (FCS) dated 5-19-17 recorded resident required physical assistance with bathing, dressing, toileting, transfers, and walking/mobility; independent with eating; and unable to perform management of medications and treatments. Frequently incontinent of bladder. Cognition: problems with short term memory circled. Problems with communication: sometimes understandable in expression and ability to understand others. Current problems/risks identified included

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S3155	Continued From page 11	S3155		

impaired hearing and impaired decision-making. Resident uses a walker and wheelchair. (Note: Coding for Cognition inaccurate as Administrative Nurse B confirmed not using FCS manual to complete the form).

The Negotiated Service Agreement (NSA) dated 5-19-17 recorded services for full body assist with all aspects of bathing and dressing. Assistance of 1 staff with toileting and use of incontinence products. RN (registered nurse)/LPN (licensed practical nurse)/CMA (certified medication aide) will administer all medications per physician orders. Monitoring of fasting blood sugar checks. The NSA indicated resident had "Dementia related issues." The NSA indicated resident was at risk for falls.

The NSA lacked identification of elopement risk including interventions to address risk; and interventions to address "dementia related issues". The NSA further lacked documentation of interventions to address fall risk.

Review of Nurse's Notes:
6-7-17 at 8:40 am: "Late entry for 6-6-17 6:40 pm. CMA (Certified Medication Aide) on duty notified this writer that resident was found wandering at the back of the building (facility). Resident stated that he/she was looking for his/her (family member) so that they can go shop for a house. Resident reoriented and brought back in the building. 30 minute checks initiated, (family member) notified and came to visit resident." Signed by Administrative Nurse B.
8-2-17 11:45 am: "Resident noted to be exit seeking on the Northwest door. Resident redirected, fluid offered. Physician and (Family member) notified of the resident's current situation...Resident oriented to surroundings."

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S3155	Continued From page 12 Signed by Administrative Nurse B. 8-22-17 at 7:00 am: CMA on east hall notified this writer that resident was on the floor. Upon arrival, resident sitting on the floor in his/her bedroom. Resident alert and stated he/she needs go to his/her bed...Resident assisted to his/her wheelchair with 2 staff. Resident dressed for the day and moved to the nursing station." Signed by Administrative Nurse B. Interview on 11-1-17 around 11:00 am with Certified Staff O stated he/she was the staff member who found the resident (on 6-6-17). Stated "when I found him/her , he/she was in the courtyard...in his/her wheelchair." Had gotten out one of the side doors into the courtyard ("where the East and West halls make a U"). We refer to it as "out back". Did not remember the exact time, stated "it was around 1 or 2 pm, right after lunch". Was alerted by another resident that "somebody was out back." Certified Staff O stated Resident #120 wheels self around the halls and is exit seeking. "Sundowners kicks in real early", usually after lunch will start saying he/she needs a ride, asking where the bus stop is and wanting to get hold of his/her spouse (who is deceased). Certified Staff O stated "we keep (Resident #120) in the lobby so we can keep eyes on him/her. Could not remember if the alarm went off on his/her pager when the door to the courtyard opened. Interview on 11-1-17 at 11:24 am with Administrative Nurse B stated resident was able to self propel wheelchair. Confirmed the NSA failed to identify the resident as an elopement risk and provide staff instruction to address the risk and further failed to identify what dementia related issues the resident had along with interventions to address those issues.	S3155		

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S3155	Continued From page 13 Administrative Nurse B stated there was a facility "Fall Prevention Plan" for the resident and provided a copy. Confirmed it was not in resident's chart nor a part of the NSA. For Resident #120, the operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident and were in accordance with the functional capacity screening and the negotiated service agreement to address the cognitively impaired resident's risk for elopement and falls.	S3155		
S3200 SS=J	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by:	S3200		

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	N046056	A. BUILDING: _____ B. WING _____	11/07/2017

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SHAWNEE HEARTLAND ASSISTED LIVING	16207 MIDLAND DRIVE SHAWNEE, KS 66217

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S3200	Continued From page 14 KAR 26-41-205(d)(2) The facility reported a census of 41 residents. The sample included 3 residents, one focus review resident and one closed record review. Based on observation, record review and interview for 1 (Resident #120) of 1 sampled resident receiving insulin, the operator failed to ensure medication aides did not administer medication through the parenteral route. This failure, placed resident # 120 in immediate jeopardy for harm, injury or death. Findings included: - Record review for Resident #120 revealed admission on 5-19-17 with diagnoses Diabetes Mellitus Type 2, Dementia and Hypertension. The Functional Capacity Screen dated 5-19-17 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement dated 5-19-17 recorded RN (registered nurse)/LPN (licensed practical nurse)/CMA (certified medication aide) will administer all medications per physician orders. Monitoring of fasting blood sugar checks. Review of record lacked documentation of an assessment of the resident's ability to self-inject insulin. Review of Medication Administration Record (MAR) for October 2017 revealed: Fasting Blood Sugar checks documented twice a day with a ranges 138-501 per Certified Medication Aides (CMAs). Novolog sliding scale as needed: 250-399 mg/dl	S3200		

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S3200	Continued From page 15 give 2 units; 400-449 give 4 units; 450-499 give 6 units; 500-549 give 8 units; above 550 call physician. Initialed as given by Certified Medication Aide D, F, G, and I. Levemir insulin inject 8 units under the skin every night at bedtime for Type 2 Diabetes Mellitus. Initialed as given by Certified Medication Aide D, H and I. Observation of Resident #120 on 10-31-17 at 2:18 pm revealed resident to be sitting and dozing in recliner in room. Easily aroused to hearing his/her name. Opened eyes and smiled briefly answered simple questions then would doze off quickly. Resident unable to stay awake at this time. Interview on 10-31-17 at 9:45 am with Administrative Nurse B confirmed Resident #120 was an insulin dependent diabetic; stated "CMAs give Resident #120 insulin, they dial the pen and inject it." Stated he/she had trained staff to administer insulin, "had done a delegation for it." Confirmed CMAs injected insulin for the resident stating, "(Resident #120) can't self-inject due to dementia." (Note: Administrative Nurse B failed to provide documentation of training CMAs to inject insulin.) Interview on 10-31-17 at 4:20 pm with Certified Medication Aide H confirmed he/she has injected insulin "a few times" for Resident #120. Stated resident's ability to self-inject has changed since admission stating "2 months ago (resident) was fine. If you guided his/her hand, he/she was able to do it." Interview on 10-31-17 at 4:26 pm with Certified Medication Aide G stated he/she dials the insulin	S3200		

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S3200	Continued From page 16	S3200		

pen, directs the resident's hand with the pen and "helps the resident push it (plunger) down."

Interview on 10-31-17 at 5:08 pm with Administrative Nurse B during personnel record reviews for Certified Medication Aides F and G, confirmed Certified Medication Aide G with date of hire 5-30-17 administered medications at the facility. Further confirmed the record lacked documentation of competency check for blood glucose monitoring and preparation of an insulin pen. Administrative Nurse B provided a copy of the competency check for Certified Medication Aide F. The competency check for "Insulin Preparation Procedure" was marked "N/A" (not applicable). Administrative Nurse B confirmed for Certified Medication Aide F, the record lacked documentation of instruction to prepare an insulin pen for administration.

Interview on 11-6-17 at 11:15 am with Administrative Nurse B stated he/she had no documentation of instruction to prepare an insulin pen for administration for Certified Medications Aides D and H. Also stated for Certified Medication Aide K he/she had documentation of instruction to prepare an insulin pen for administration. Confirmed no documentation of instruction to prepare an insulin pen for administration for Certified Medication Aide I.

Review of facility policy regarding "Medication Management" and the "CMA Guidelines" lacked documentation that certified medication aides shall not administer medication through the parenteral route.

For Resident #120, the operator failed to ensure medication aides did not administer medication through the parenteral route when CMAs

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S3200	Continued From page 17 administered insulin to the resident. This failure placed the resident in immediate jeopardy for harm, injury or death. The jeopardy was removed on 10-31-17, when Administrative Nurse B stated he/she had spoken with the nurse practitioner and provided a written plan to address issue of certified staff administering insulin which stated the following: a) Change Levemir insulin to 10 units at 8:00 am starting 11-1-17. b) Increase Metformin to 1000 mg (milligrams) by mouth twice a day starting 10-31-17. c) Recheck Hemoglobin A1C the week of 2-1-18. d) Resident may self-inject insulin subcutaneously as needed with staff observation. New orders: Home Health Nursing on weekends and as needed. Order submitted to a (home health agency) awaiting feedback. Follow up interview with Administrative Nurse B on 10-31-17 at 5:15 pm regarding written plan stated if he/she was unable to find a home health agency to come to administer on the weekend, he/she would come in to give the insulin.	S3200		
S3310 SS=E	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	S3310		

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S3310	Continued From page 18 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: KAR 26-41-207(c) The facility reported a census of 41 residents. The sample included 3 residents, one focus review resident and one closed record review. Based on record review and interview for 2 (Non-Certified Staff L and Certified Staff M) of 5 sampled personnel records and 1 (#116) of 3 sampled residents, the operator failed to ensure the facility's compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Personnel Record Review on 10-31-17 at 5:00 pm with Operator and Administrative Nurse B revealed the following: Non-Certified Staff L with date of hire 5-22-17: the record contained a tuberculosis (TB) symptom screen dated 5-22-17. The record lacked documentation of 2-Step TB skin testing. Certified Staff M with date of hire 7-28-17: The record contained a TB symptom screen dated 8-18-17. The record contained a 1-Step TB skin test dated 8-8-17. The record lacked documentation of TB skin testing initiated within 7 days of hire and a second TB skin test.	S3310		

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S3310	Continued From page 19 Interview on 10-31-17 at 5:20 pm with Administrative Nurse B and Operator, confirmed the record lacked documentation of the above TB skin testing. - Record review for Resident #116 revealed admission on 9-13-17. The record contained a TB symptom screen dated 9-13-17. The record lacked documentation of TB skin testing. Interview on 10-31-17 at 5:22 pm with Administrative Nurse B confirmed the record lacked documentation of a 2-Step TB skin test. For 2 sampled staff and Resident #116, the operator failed to ensure the facility's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference K.A.R. 26-39-105.	S3310		
S3420 SS=F	28-39-256 MECHANICAL REQUIREMENTS (c) Mechanical requirements. (1) Heating, air conditioning, and ventilating systems. (A) The system shall be designed to maintain a year-round indoor temperature range of 70oF or 21oC to 85oF or 26oC. (B) Each apartment or individual living unit shall allow the resident to control the temperature. (2) Plumbing and piping systems. (A) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which	S3420		

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S3420	Continued From page 20 hoses or tubing can be attached. (B) Water distribution systems shall be arranged to provide hot water at outlets at all times. The temperature of hot water shall range between 98oF and 120oF at bathing facilities, sinks, and lavatories in resident use areas. (3) Electrical requirements. (A) All spaces occupied by persons or machinery and equipment within the buildings, approaches to buildings, and parking lots shall have adequate lighting. (B) Minimum lighting intensity levels shall be as required in Table 1. (C) Each corridor and stairway shall remain lighted at all times. (D) Each light in resident use areas shall be equipped with shades, globes, grids, or glass panels. This REQUIREMENT is not met as evidenced by: KAR 28-39-256(c)(3)(B) The facility reported a census of 41 residents. The sample included 3 residents, one focus review resident and one closed record review. For all residents, the operator failed to ensure all spaces occupied by persons or machinery and equipment within the building had adequate lighting with minimum lighting intensity levels as required evidenced by observations and interview.	S3420		

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S3420	Continued From page 21 Findings included: - Observations during entrance tour of facility accompanied by Operator on 10-31-17 from 2:40 pm to 3:34 pm revealed the following dim lighting assessed by two different foot candle meters to verify findings: Lighting in corridors at floor level in both the east hall and west hall recorded as 1 to 2 foot candles; the minimum lighting intensity level is 10 foot candles. Living Room Common areas three feet above floor by the sofa in both the east and west hall sitting area recorded as 3 to 5 foot candles; the minimum light intensity level is 15 foot candles Area for reading measured at the chair or table area for chairs set next to a corner table with a lamp in both east and west halls recorded as 10 to 11 foot candles; the minimum light intensity level if 50 foot candles. Interview on 10-31-17 at 11:00 am with Operator, confirmed all the above readings. Observations during survey on 10-31-17 at 4:20 pm revealed certified medication aides with medication carts in these above common areas reading the medication administration records and passing medications in the dimly lit common areas and corridors. For all residents, the operator failed to ensure all spaces occupied by persons or machinery and equipment had adequate lighting with minimum lighting intensity levels as required.	S3420		