

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N047002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2015
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PLACE LAKIN, KS 67860		
(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 Health Licensure Resurvey.	S 000		
S 135 SS=D	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment. This STANDARD is not met as evidenced by: The facility had a census of 25 residents with 3 sampled for review. Based on observation, interview, and record review, the facility failed to notify 1 of 3 resident's physician of a change in his/her condition when the resident's pressure ulcer worsened and he/she developed new	S 135		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S 135	Continued From page 1 pressure ulcers. (#3) Findings included: - Resident #3's 6/30/15 admission Functional Capacity Screen revealed the resident was oriented to self and the environment, required assistance 1-2 times per day for transfers, occasional assistance with toileting, and intermittent supervision with dressing. The resident also required medication management services from the facility. Resident #3's 9/29/15 Health Service Plan indicated the resident had full memory recall, used a walker to ambulate and walked unassisted. The plan directed staff to assist the resident with bathing, administer medications, and assist with dressing changes to the buttocks and upper right shoulder. Review of the clinical record lacked evidence of development of a Health Service Plan at the time of admission on 6/30/15 when the resident required more assistance with transfers, toileting, dressing, and medication management. A monthly nursing assessment dated 8/22/15 indicated resident #3's skin was free of pressure ulcers. A care note dated 9/15/15 written by licensed nurse C stated he/she faxed the physician regarding a sore on the resident's bottom between his/her buttocks. The physician responded with an order to apply barrier cream with Mepilex (type of adherent foam dressing) and to notify the physician if the area worsened or did not improve in 1 week. Review of the care notes lacked any further documentation related to the resident's pressure ulcer, condition of	S 135		

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S 135	Continued From page 2 dressings or surrounding tissue, or development of any new pressure areas. The 9/15/15 fax communication to the physician stated the resident had an open sore measuring 0.4 cm (centimeters) in diameter on his/her bottom between the buttocks. The physician responded on the same day with an order to continue use of the barrier cream with the Mepilex dressing and requested that staff notify him/her in 1 week if the area worsened or did not improve. Resident #3's 9/22/15 monthly nurse assessment completed by licensed nurse C noted the resident had skin breakdown on bilateral buttocks and placed Duoderm (a hydrocolloid dressing) on the area of skin breakdown. The assessment lacked measurements or a description of the appearance of the wound or wounds. Review of the clinical record lacked documentation of further measurements, description of the resident's wound or wounds, notification of the physician if the wound worsened or had no improvement, or implementation of any interventions to promote healing such as pressure reduction devices or nutritional supplements. A 9/28/15 fax communication to the physician reported the resident had complaints of left knee pain and currently received Tylenol and Mobic (anti-inflammatory medications) for pain. The fax further stated the resident was more inactive due to the pain and now had 2 open areas on the coccyx (tailbone) and redness to the right shoulder from pressure and inactivity. Nurse C reported staff currently applied extra thin Duoderm to the coccyx area and a Mepilex pad to	S 135			

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S 135	Continued From page 3 the shoulder. Nurse C also reported that staff turned the resident every 2 hours, used an inflatable donut while in the chair, and asked if this treatment was okay. Nurse C also requested an order for a protein shake to aid in healing. As of 9/30/15 at 2:45 p.m. the facility had no response from the physician and failed to make further attempts to contact the physician. During an observation on 9/30/15 at 1:40 p.m., resident #3 rested in his/her bed (no pressure relief mattress in place) with the head of the bed elevated approximately 30 degrees. The resident was alert, oriented and communicated about his/her condition. The resident confirmed that he/she had a sore on his/her buttocks and indicated the dressing came off earlier in the day and he/she forgot to tell staff. After notifying the staff, Nurse C entered the resident's room at 2:20 p.m. to apply a new dressing. The resident was able to stand without difficulty with support from his/her walker. There was no dressing on the resident's buttocks. By observation, the resident had an unopened area on the inner left buttock that was a darkened, purple hue and approximately 0.5 by 1 cm in size. The right buttock had an open area with a red wound bed and approximately 1 cm by 1 cm in size. Nurse C cleansed both wounds with normal saline and applied a Duoderm cover dressing to the area. The wounds were on the inner buttocks on both sides of the coccyx and the coccyx area was free of any wounds. After applying the dressing, the resident ambulated to his/her recliner using a walker without difficulty. The recliner had an inflatable donut cushion in the seat. While seated in the recliner, Nurse C removed the Mepilex dressing from the resident's right shoulder. He/she stated that nursing staff changed the shoulder dressing daily and the dressing to the	S 135		

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S 135	Continued From page 4 buttocks every 72 hours. The resident's right shoulder had an open area approximately 2.5 cm by 3 cm in size with a red, beefy wound bed with yellow exudate and serosanguinous (bloody, serous fluid) drainage. After cleansing the area, nurse C applied a Mepilex dressing and indicated the area worsened since that last time he/she looked at the area. An interview on 9/30/15 at 2:45 p.m. with licensed nurse C revealed that when the resident first came to the facility he/she received therapy services and improved after admission. The resident walked a lot and became more mobile with therapy. Nurse C stated that recently the resident had more knee pain and became less active and spent more time in his/her recliner. Nurse C verified he/she identified the first pressure ulcer on 9/15/15 and faxed the physician for a treatment order. Nurse C was aware the physician ordered for staff to notify him/her in 1 week if the area worsened or did not improve. Nurse C confirmed that he/she assessed the resident's buttocks on 9/22/15 on the monthly assessment stated the area worsened at that time. Nurse C verified he/she failed to notify the physician of the worsened condition of the pressure ulcer and indicated that he/she did not measure pressure ulcers in the assisted living facility. Licensed nurse C further revealed that he/she faxed the physician on 9/28/15 regarding the 2 open areas to the resident's coccyx and redness to the resident's right shoulder. Nurse C verified that he/she decided to try the Duoderm dressing on 9/22/15 instead of the Mepilex for the areas on the resident's buttocks without a physician's order for a change in treatment. According to nurse C, the area on the resident's shoulder was first identified on 9/28/15 as a reddened area, to the best of	S 135		

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S 135	Continued From page 5 his/her knowledge. Nurse C confirmed the shoulder pressure ulcer was now open with drainage present. Nurse C also verified the facility did not receive any response from the physician from the fax sent on 9/28/15 as of 9/30/15 and no attempts were made to contact the physician by fax or phone regarding the resident worsening pressure ulcers. Nurse C indicated the facility did not have a protocol for physician notification or follow-up on faxes sent to physicians. During an interview on 9/30/15 at 3:20 p.m., administrative nurse A was unaware of resident #3's pressure ulcers. An unsuccessful attempt was made to interview the resident's physician as he/she was unavailable for 2 weeks. Although requested, the assisted living facility lacked any policies or procedures for physician notification. The facility failed to notify the physician of worsening of a pressure ulcer or development of new pressure ulcers for resident #3.	S 135		
S 375 SS=G	28-39-152(c) PRESSURE ULCERS (c) Pressure ulcers. Based on the comprehensive assessment, the facility shall ensure all of the following: (1) Any resident who enters the facility without pressure ulcers does not develop pressure ulcers, unless the resident's clinical condition demonstrates that they were unavoidable. The facility shall report in writing the development of	S 375		

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S 375	Continued From page 6 any pressure ulcer to the medical director. (2) Any resident with pressure ulcers receives the necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 25 residents with 3 sampled for review. Based on observation, interview, and record review, the facility failed to provide treatment and services for 1 of 3 sampled residents to prevent pressure ulcers from developing and to promote healing. Resident #3 developed 3 pressure ulcers after admission to the facility on 7/6/15. The facility failed to adequately assess and monitor pressure ulcers, implement appropriate measures to promote healing and prevent new pressure ulcers from developing, and provide the prescribed treatment for resident #3. Findings included: - Resident #3's 6/30/15 admission Functional Capacity Screen revealed the resident was oriented to self and the environment, required assistance 1-2 times per day for transfers, occasional assistance with toileting, and intermittent supervision with dressing. The resident also required medication management services from the facility. Resident #3's 9/29/15 Health Service Plan indicated the resident had full memory recall, used a walker to ambulate and walked unassisted. The plan directed staff to assist the resident with bathing, administer medications,	S 375			

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S 375	Continued From page 7 and assist with dressing changes to the buttocks and upper right shoulder. Review of the clinical record lacked evidence of development of a Health Service Plan at the time of admission on 6/30/15 when the resident required more assistance with transfers, toileting, dressing, and medication management. A monthly nursing assessment dated 8/22/15 indicated resident #3's skin was free of pressure ulcers. A care note dated 9/15/15 written by licensed nurse C stated he/she faxed the physician regarding a sore on the resident's bottom between his/her buttocks. The physician responded with an order to apply barrier cream with Mepilex (type of adherent foam dressing) and to notify the physician if the area worsened or did not improve in 1 week. Review of the care notes lacked any further documentation related to the resident's pressure ulcer, condition of dressings or surrounding tissue, or development of any new pressure areas. The 9/15/15 fax communication to the physician stated the resident had an open sore measuring 0.4 cm (centimeters) in diameter on his/her bottom between the buttocks. The physician responded on the same day with an order to continue use of the barrier cream with the Mepilex dressing and requested that staff notify him/her in 1 week if the area worsened or did not improve. Resident #3's 9/22/15 monthly nurse assessment completed by licensed nurse C noted the resident had skin breakdown on bilateral buttocks and placed Duoderm (a hydrocolloid dressing) on the area of skin breakdown. The assessment lacked	S 375		

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S 375	Continued From page 8 measurements or a description of the appearance of the wound or wounds. Review of the clinical record lacked documentation of further measurements, description of the resident's wound or wounds, notification of the physician if the wound worsened or had no improvement, or implementation of any interventions to promote healing such as pressure reduction devices or nutritional supplements. Review of the physician orders lacked evidence of an order for the Duoderm dressing that staff implemented on 9/22/15 in place of the ordered Mepilex dressing. A 9/28/15 fax communication to the physician reported the resident had complaints of left knee pain and currently received Tylenol and Mobic (anti-inflammatory medications) for pain. The fax further stated the resident was more inactive due to the pain and now had 2 open areas on the coccyx (tailbone) and redness to the right shoulder from pressure and inactivity. Nurse C reported staff currently applied extra thin Duoderm to the coccyx area and a Mepilex pad to the shoulder. Nurse C also reported that staff turned the resident every 2 hours, used an inflatable donut while in the chair, and asked if this treatment was okay. Nurse C also requested an order for a protein shake to aid in healing. As of 9/30/15 at 2:45 p.m. the facility had no response from the physician and failed to make further attempts to contact the physician. A care note written on 9/30/15 at 2:32 p.m. stated nurse C changed the Duoderm to the resident's buttock's area and indicated the wound was healing. He/she described the wound as a	S 375			

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S 375	Continued From page 9 scabbed area that was 0.3 cm by 0.4 cm, approximately. The note further stated the right shoulder blade pressure ulcer was 2 cm by 3 cm, approximately, and cleansed both the buttock and shoulder with normal saline. The note stated staff applied a Mepilex dressing to the shoulder area. The care note lacked a description of the shoulder blade wound or if the wound was open or had drainage. During an observation on 9/30/15 at 1:40 p.m., resident #3 rested in his/her bed (no pressure relief mattress in place) with the head of the bed elevated approximately 30 degrees. The resident was alert, oriented and communicated about his/her condition. The resident confirmed that he/she had a sore on his/her buttocks and indicated the dressing came off earlier in the day and he/she forgot to tell staff. After notifying the staff, Nurse C entered the resident's room at 2:20 p.m. to apply a new dressing. The resident was able to stand without difficulty with support from his/her walker. There was no dressing on the resident's buttocks. By observation, the resident had an unopened area on the inner left buttock that was a darkened, purple hue and approximately 0.5 by 1 cm in size. The right buttock had an open area with a red wound bed and approximately 1 cm by 1 cm in size. Nurse C cleansed both wounds with normal saline and applied a Duoderm cover dressing to the area. The wounds were on the inner buttocks on both sides of the coccyx and the coccyx area was free of any wounds. After applying the dressing, the resident ambulated to his/her recliner using a walker without difficulty. The recliner had an inflatable donut cushion in the seat. While seated in the recliner, Nurse C removed the Mepilex dressing from the resident's right shoulder. He/she stated that nursing staff changed the	S 375		

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S 375	Continued From page 10 shoulder dressing daily and the dressing to the buttocks every 72 hours. The resident's right shoulder had an open area approximately 2.5 cm by 3 cm in size with a red, beefy wound bed with yellow exudate and serosanguinous (bloody, serous fluid) drainage. After cleansing the area, nurse C applied a Mepilex dressing and indicated the area worsened since that last time he/she looked at the area. During an interview on 9/30/15 at 2:30 p.m., direct care staff D stated resident #3 would ask staff when he/she needed assistance. Staff D stated they mostly helped with showers and he/she repositioned him/herself in bed. Staff D indicated the resident did not have a turning or repositioning schedule. Direct care staff D was aware the resident had "sores" and stated the nurses provided the wound care. An interview on 9/30/15 at 2:45 p.m. with licensed nurse C revealed that when the resident first came to the facility he/she received therapy services and improved after admission. The resident walked a lot and became more mobile with therapy. Nurse C stated that recently the resident had more knee pain and became less active and spent more time in his/her recliner. Nurse C verified he/she identified the first pressure ulcer on 9/15/15 and faxed the physician for a treatment order. Nurse C indicated that even though the fax stated the sore was between the buttocks, he/she stated it was more on the right buttock. Nurse C was aware the physician ordered for staff to notify him/her in 1 week if the area worsened or did not improve. Nurse C confirmed that he/she assessed the resident's buttocks on 9/22/15 on the monthly assessment stated the area worsened at that time. Nurse C verified he/she failed to notify the	S 375		

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S 375	Continued From page 11 physician of the worsened condition of the pressure ulcer and indicated that he/she did not measure pressure ulcers in the assisted living facility. Licensed nurse C further revealed that he/she faxed the physician on 9/28/15 regarding the 2 open areas to the resident's coccyx and redness to the resident's right shoulder. Nurse C verified that he/she decided to try the Duoderm dressing on 9/22/15 instead of the Mepilex for the areas on the resident's buttocks without a physician's order for a change in treatment. According to nurse C, the area on the resident's shoulder was first identified on 9/28/15 as a reddened area, to the best of his/her knowledge. Nurse C confirmed the shoulder pressure ulcer was now open with drainage present. Nurse C also verified the facility did not receive any response from the physician from the fax sent on 9/28/15 as of 9/30/15 and no attempts were made to contact the physician by fax or phone regarding the resident worsening pressure ulcers. Nurse C indicated the facility did not have a protocol for physician notification or follow-up on faxes sent to physicians. He/she also stated the treatments provided to resident #3 were not documented on the MAR (mediation administration record) or on a TAR (treatment administration record) and the only documentation would be in the monthly assessment or care notes. Nurse C also confirmed resident #3 did not have a pressure relief device on his/her bed, was unaware of the effects of inflatable donuts for pressure relief, and verified the resident did not receive and nutritional supplements to promote healing. During an interview on 9/30/15 at 3:20 p.m., administrative nurse A was unaware of resident #3's pressure ulcers.	S 375		

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S 375	Continued From page 12 An unsuccessful attempt was made to interview the resident's physician as he/she was unavailable for 2 weeks. Although requested, the assisted living facility lacked any policies or procedures for the assessment and treatment of pressure ulcers. According to www.nlm.nih.gov/medlineplus/ency/article , "Donut-shaped or ring-shaped cushions are not recommended. They interfere with blood flow to that area and cause complications." The facility failed to implement measures to prevent pressure ulcers when resident #3 became less mobile due to knee pain. After the resident developed a pressure ulcer the facility failed to implement appropriate pressure relief measures, failed to notify the physician of worsening pressure areas and development of new pressure ulcers so that appropriate treatments could be ordered, and failed to assess, monitor, and document the condition of the wounds including measurements. The facility also failed to follow the physician's orders for pressure ulcer treatments. The resident acquired 3 pressure ulcers while residing in the assisted living facility.	S 375		
S 640 SS=E	28-39-158(g) SANITARY CONDITIONS (2) The facility shall store, prepare, display, distribute, and serve foods to residents, visitors and staff under sanitary conditions. (A) The facility shall keep potentially hazardous foods at a temperature of 45oF or 7oC or lower, or at a temperature of 140oF or 60oC or higher.	S 640		

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S 640	Continued From page 13 (B) The facility shall provide each mechanically refrigerated storage area with a numerically scaled thermometer, accurate to +plus or -minus 3oF or 1.5oC, which is located to measure the warmest part of the storage area and is easily readable. (C) The facility shall keep frozen food frozen and shall store the food at a temperature of not more than OoF. This REQUIREMENT is not met as evidenced by: The facility had a census of 25 residents with 2 dining rooms. The main kitchen of the facility prepared foods served to the hospital, long-term care unit, and the assisted living facility. Based on observation, interview, and record review, the facility failed to serve foods in a sanitary manner in 1 of 2 dining rooms in the assisted living facility. (300 hall) Findings included: - During an observation on 9/30/15 at 11:45 a.m., dietary staff G prepared to serve residents in the 300 hall dining room from a steam table with food prepared in the main kitchen of the facility. Staff G had utensils in the sweet and sour chicken, snap peas, rice, and a stainless steel container holding other foods either wrapped in foil or in zip lock bags with lids on each metal container in the steam cart. Staff G referred to a notebook laying on the counter beside the steam cart that had the resident's orders for the noon meal. Dietary staff G wore gloves as he/she prepared the orders for the residents. He/she touched the lids, the counter, the face of a drawer, and the notebook	S 640		

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S 640	Continued From page 14 on the counter. Staff G then used the contaminated glove to hold pieces of chicken in place as he/she cut the chicken in to bite size pieces for one resident. Staff G then changed his/her gloves, washed hands, then picked up a stainless steel pan on the bottom shelf of the steam cart to move it to another area. He/she continued to touch other non-clean items then picked up meat, lettuce, tomatoes, and pickles with the contaminated gloves while preparing sandwiches. He/she also picked up chicken strips and baked potatoes with contaminated gloves and held the potatoes with the gloved hand while cutting it up. Staff G changed his/her gloves and washed hands periodically, however, continued to contaminate the gloves by touching unclean surfaces, then touching the foods being served. During an interview on 9/30/15 at 12:30 p.m. dietary staff G stated he/she was nervous and stated he/she did contaminate his/her gloves while serving food. During an interview on 9/30/15 at 1:15 p.m., dietary staff H stated staff should remove gloves after contamination and should use utensils or tongs to touch foods while serving. Although requested, the facility failed to provide a policy for sanitary food service. The facility failed to serve foods in a sanitary manner in the 300 hall dining room.	S 640		
S2060 SS=C	26-43-101 (I) Survey Report (I) Survey report and plan of correction. Each administrator or operator shall ensure that a copy	S2060		

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S2060	Continued From page 15 of the most recent survey report and plan of correction is available in a public area to residents and any other individuals wishing to examine survey results. This REQUIREMENT is not met as evidenced by: The facility had a census of 25 residents with 2 halls (300 and 400). Based on observation, interview, and record review, the facility failed to ensure a copy of the most resident survey report and plan of correction remained in a public area accessible to residents or any other individuals. Findings included: - During an observation on 9/30/15 at 9:20 a.m., a sign posted at the entrance of the 300 hall of the assisted living facility stated the survey results were available in the business office of the LTCU (long-term care unit). Observation in the LTCU revealed a notebook located on the counter of at the business office window that failed to include the most recent survey results for the assisted living facility. During an interview on 9/30/15 at 9:25 a.m., administrative staff B confirmed the notebook located in the LTCU was not accessible to the residents living in the assisted living facility and did not contain the most recent survey results. The facility failed to ensure the most recent survey report was accessible to residents and others who wished to read the report.	S2060		
S2235 SS=D	26-43-205 (h) Medication Storage (h) Storage. Licensed nurses and medication	S2235		

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S2235	Continued From page 16 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 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: The facility had a census of 25 residents with 2 halls (300 and 400) and 2 medication carts. Based on observation, interview, and record review, the facility failed to ensure expired medication were not available for use in the 300	S2235		

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S2235	Continued From page 17 hall medication cart. Findings included: - During an observation on 9/30/15 at 11:30 a.m., direct care staff E unlocked the medication cart on the 300 hall for inspection. The cart contained 2 bottles of Omega T vitamins with an unsampled resident's name on the bottles. The Omega T vitamin bottles had expiration dates of July 2014 and April 2015. During an interview on 9/30/15 at 10:30 a.m., direct care staff D stated expiration dates for medications should be checked monthly by the CMAs (certified medication aides). An interview on 9/30/15 at 11:35 a.m. with direct care staff E revealed medications that expired should be removed from the medication cart. According to staff E the CMAs checked for outdated medications at the time they administer medications. An interview on 9/30/15 at 3:20 p.m. with administrative staff A confirmed expired medications should be discarded and not available for use. The facility's March 2005 Medication Management Storage stated, all drugs in the facility shall be stored safely, securely, and properly, following manufacturer's recommendations. The facility failed to discard expired medications for an unsampled resident stored in the 300 hall medication cart.	S2235		

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S2255	Continued From page 18	S2255			
S2255 SS=F	26-43-205 (k) (2) Medication Regimen Review Variance Report (k) (2) The licensed pharmacist or licensed nurse shall report each variance identified in the medication regimen review to the resident 's medical care provider. This REQUIREMENT is not met as evidenced by: The facility had a census of 25 residents. Based on interview and record review, the facility failed to ensure the consultant pharmacist that conducted the quarterly medication regimen reviews reported each variance to the residents' medical care provider. Findings included: - Review of two sampled resident's clinical records lacked evidence of a medication regimen reviews after 7/1/14. During an interview on 9/30/15 at 3:20 p.m., administrative nurse A revealed after 7/1/14, the consultant pharmacist documented the medication reviews in their electronic medical record system. According to nurse A, he/she was the only staff person that had access to the pharmacist reviews. Nurse A further stated the pharmacist usually called the nurse on duty with any concerns and did not directly report the concerns to the medical provider and this affected all of the residents in the assisted living that received medication regimen reviews. The facility failed to ensure the consultant pharmacist reported variances in medication regimen reviews to the residents' medical care	S2255			

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S2255	Continued From page 19 provider.	S2255		
S2335 SS=C	26-43-104 (e) Emergency Plan Available (e) Each administrator or operator shall make the emergency management plan available to the staff, residents, and visitors. This REQUIREMENT is not met as evidenced by: The facility had a census of 25 residents with 2 halls (300 and 400). Based on observation and interview, the facility failed to make the emergency management plan available to residents and visitors. Findings included: - An initial tour of the facility on 9/28/15 at 11:00 a.m. of the 300 and 400 halls revealed no evidence of an emergency management plan made available to residents or visitors. During an interview on 9/30/15 at 9:20 a.m., administrative staff B was unaware of the requirement to make the emergency plan available to residents and visitors. During an interview on 9/30/15 at 3:20 p.m., administrative nurse A was unaware of the requirement to make the emergency plan available to residents and visitors. The facility failed to make the emergency management plan available to residents and visitors.	S2335		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment	S3081		

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S3081	Continued From page 20 (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: The facility had a census of 25 residents with 3 sampled for review. Based on observation, interview, and record review, the facility failed to complete a functional capacity screen for 1 of 3 sampled residents at least once every 365 days. (#2) Findings included: - Review of resident #2's most recent Functional Capacity Screen dated 5/29/14 revealed the resident was independent with all ADLs (activities of daily living). Review of the clinical record lacked evidence of completion of a Functional Capacity Screen within 365 days of the last screen completed on 5/29/14. During an observation on 9/30/15 at 1:15 p.m., resident #2 ambulated independently in his/her apartment. The resident was well-groomed and able to make his/her needs known. During an interview on 9/30/15 at 3:20 p.m.,	S3081		

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S3081	Continued From page 21 administrative nurse A confirmed the facility did not complete the annual Functional Capacity Screen for resident #2 within the required time frame. The facility failed to complete resident #2's annual Functional Capacity Screen within 365 days as required.	S3081		
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 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: The facility had a census of 25 residents with 3 sampled for review. Based on observation, interview, and record review, the facility failed to ensure qualified staff developed the negotiated service agreement. (#1)	S3085		

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S3085	Continued From page 22 Findings included: - The signature page of Resident #1's 5/13/15 Negotiated Service Agreement indicated administrative staff B signed the form as completing the agreement. During an observation on 9/30/14 at 1:30 p.m., resident #1 sat in a recliner in his/her apartment with a walker and call light within reach. The resident was alert and able to make his/her needs known. During an interview on 9/28/15 at 9:20 a.m. administrative staff B verified he/she was a CNA (certified nurse aide) without an operator's certificate. Staff B stated his/her title was director of the assisted living facility and indicated he/she planned to take the operator's course for certification. During an interview on 9/28/15 at 3:20 administrative staff A confirmed the negotiated service agreement should be developed by the administrator or operator of the facility or the licensed nurse. The facility failed to ensure qualified staff completed the negotiated service agreement in collaboration with the resident.	S3085		