

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N063013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/31/2015
NAME OF PROVIDER OR SUPPLIER GUEST HOME ESTATES		STREET ADDRESS, CITY, STATE, ZIP CODE 400 S MCGEE CANEE, KS 67333		
(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 investigation 85329 at the above named residential health care facility on 3-25-15, 3-26-15, 3-30-15 and 3-31-15.	S 000		
S 195 SS=D	26-39-102 (f) Discharge Notice (f) The administrator or operator, or the designee, shall provide a notice of transfer or discharge in writing to the resident or resident ' s legal representative at least 30 days before the resident is transferred or discharged involuntarily, unless one of the following conditions is met: (1) The safety of other individuals in the adult care home would be endangered. (2) The resident's urgent medical needs require an immediate transfer to another health care facility. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(f) The facility reported a census of 23 residents and one day care resident. The sample included 3 residents and 2 focus review residents. Based on record review and interview for 1(#110) of 1 day care residents, the operator failed to provide a notice of transfer or discharge in writing to the resident and/or resident's legal representative at least 30 days before the resident was transferred or involuntarily discharged to another facility. Findings included: - Record review for resident #110 revealed	S 195		

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

TITLE

(X6) DATE

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S 195	Continued From page 1 admission on 1-12-15 with diagnosis of Dementia. The functional capacity screen dated 1-12-15 recorded resident required physical assistance with bathing and management of treatments; independent with dressing, transfers, walking/mobility and eating; and unable to perform management of medications. The negotiated service agreement/health care service plan dated 1-12-15 recorded services for staff to provide reminders for toileting, meals and activities; and "Health Care Services: Medication Assistance: staff to set up, administer and store all medications." Review of residency agreement under "Termination" stated: "2. Termination by facility: Except in the case of emergencies, facility may terminate this agreement at any time upon thirty (30) days written notice with or without cause. (Facility) shall have a policy of terminating this agreement, at its discretion, if any of the following events occur: a. Failure to pay all fees within 10 days after the due date; b. For medical or behavioral reasons which render this facility an inappropriate placement. c. For health, safety, and well-being of the resident or others; d. Failure to comply with state or local law after receiving written notice of a violation; e. Failure to comply with the policies of facility; f. The use of facility changes or ceases to be in operation. Review of resident's record on 3-25-15 and 3-26-15 revealed the record lacked documentation of resident's health, medical or behavioral status to substantiate reason for discharge and further lacked documentation of a	S 195		

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S 195	Continued From page 2 written 30-day discharge notice. Observation of resident on 3-25-15 revealed resident sitting in the sunroom dozing and watching television. Later, around 3:45 pm, resident ambulated to the dining room and talked with another resident for quite a while. Pleasantly confused when interacting with other residents and staff. Observation on 3-26-15 at 10:30 am revealed resident absent from facility. Interviews on 3-26-15 at 11:00 am and 3:24 pm and with administrative nurse #A confirmed resident was not in facility today (3-26-15) and would not be returning, stated he/she was being discharged and they were helping family find another placement; further confirmed facility did not give a 30 day written notice to the resident. For resident #110, the operator failed to provide a notice of discharge in writing to the resident and/or resident's legal representative at least 30 days before the resident was involuntarily discharged to another facility.	S 195		
S3028 SS=E	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.	S3028		

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S3028	Continued From page 3 (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) The facility reported a census of 23 residents and one day care resident. The sample included 3 residents and one focus review resident. Based on record review and interview for 1 (#109, #110) of 3 sampled residents, the operator failed to ensure each allegation of abuse neglect or exploitation shall be reported to the department within 24 hours and an investigation shall be started when the operator receives the notification of an alleged violation. Findings included: - Record review for resident #109 revealed admission on 12-31-13 with diagnoses Alzheimer ' s Dementia (other diagnoses from hospital	S3028		

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S3028	Continued From page 4 record included Hypertension and Osteoarthritis). The functional capacity screen (FCS) dated 12-31-13 recorded resident required physical assistance with bathing, dressing, and walking/mobility; supervision with toileting, transfers and eating; and unable to perform management of medications/treatments. Occasionally incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks: falls/unsteadiness (" Fall at home with hospitalization prior to admit. Exhibits unsteadiness when walking. ") Updated on 1-6-14 " resident oriented to self, time, room, and place " (note: resident had urinary tract infection at admission affecting cognition). The negotiated service agreement/health care service plan (NSA/HSP) dated 12-31-13 recorded the following services: Bathing: shower assist 2 times per week. Toileting: stand by assistance, staff will assist on and off as needed. Staff will apply briefs at bedtime and as needed. Mobility/Walking: ambulate with walker, staff will monitor in hallway. Wheelchair for periods of pain. Staff to assist with walker or wheelchair. Dressing: staff will assist with dressing and clothing selection. Transferring: Stand by assistance as needed. Sleep Cycle Support: Staff will check on resident every 2 hours at night. Additions to NSA/HCSP: 1-21-14: " Fell in room, fractured femur. Educated resident to use call light and walker. Resident verbalized understanding of instruction. " 4-4-14: " Fell in room. Reviewed previous	S3028		

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S3028	Continued From page 5 instruction on using call light and waiting until help arrives. Educated and reminded resident to wear brief and call for assistance changing and wear shoes/slippers at all times when ambulating. " 4-28-14: " Found sitting up on floor in front of refrigerator in resident ' s room. Re-educated on call light use, wait until staff arrives. Use walker, wear shoes. " 5-17-14: " Resident slipped and fell leaving bathroom in room. Resident re-educated to use call light, use walker, depends and wear slippers. " 10-6-14: " Resident fell trying to go down the hallway in front of doorway. Order for physical therapy evaluation. " Nurse ' s notes documented the following: 10-9-14 at 3:00 pm and 8:00 pm: " Resident came to breakfast and lunch with aide of walker. Ate 75% at both meals. Skin tear on right arm from fall previously was bleeding and in need of attention. Steri-strips and dressing applied at this time. Resident was very agitated and not following directions well. This progressed through all of 2nd shift. This resident is high fall risk and was found on the floor 2-3 times today. Won ' t stay down and can ' t remember what he/she got up for. " Signed by certified staff E. 10-21-14 at 2:45 pm: " Nurse contacted (family member) about resident ' s change in condition. (Family member) will pick up resident to take to hospital ... " Signed by licensed staff C. (hospital report: x-ray of right shoulder dated 10-21-14: " Oblique fracture proximal humeral shaft with distal fracture fragment completely displaced anteriorly with 2 cm overriding. Chronic degenerative changes at the right shoulder with	S3028		

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S3028	Continued From page 6 increased superior subluxation of humeral head and fracture laterally end of deformed right clavicle and medial end of deformed acromion process of scapula.) Interview with operator on 3-26-15 at 2:32 pm and 3-30-15 at 2:40 pm stated the " change in condition " documented in the record on 10-21-14 was " he/she was out of it in the head, not making much sense and talking about dead people. " Operator stated he/she couldn ' t remember resident having a fall on that day, and he/she did not know how the resident ' s arm came to be fractured. Confirmed he/she failed to report this injury of unknown origin to the department within 24 hours and perform an investigation. For resident #109 who experienced a right arm fracture, the operator failed to report the injury of unknown origin to the department and start an investigation to determine how the arm became fractured. - Record review for resident #110 revealed admission on 1-12-15 with diagnosis of Dementia. The functional capacity screen dated 1-12-15 recorded resident unable to perform management of medications and treatments. The negotiated service agreement/health care service plan dated 1-12-15 recorded "Health Care Services: Medication Assistance: staff to set up, administer and store all medications." Physician's telephone order dated 2-5-15: "Seroquel 25 milligrams 1 tablet by mouth in the morning." Review of Medication Administration Record for	S3028		

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S3028	Continued From page 7 January, February 2015 revealed resident receiving Seroquel as ordered at 8:00 am daily; then at 9:00 am daily in March 2015. The record lacked any documentation in Nurse's Notes. Interviews on 3-25-15 at 1:32 pm and 3-26-15 at 10:45 am with operator stated certified staff H turned in a complaint to the company hotline alleging another staff member had given resident #110 "too much medication" because the resident was sleeping throughout the day. Stated, "corporate came and investigated." Confirmed the allegation of abuse or neglect was not reported to the department by the facility. Interview on 3-26-15 at 11:00 am with administrative nurse A confirmed he/she was on call for any nursing needs beginning 3-20-15 at 3:00 pm. Stated no facility staff called him/her with any resident concerns. Further stated he/she was notified by the corporate nurse of the allegation on Sunday 3-22-15 and "we came over on Tuesday (3-24-15) to investigate." Confidential interview stated, "certified staff G gave resident #110 the Seroquel that he/she gets daily and around noon, certified staff G called the boss and asked if he/she could give resident #110 a Benadryl. So after lunch certified staff G gave resident #110 two Benadryl and resident slept in the sunroom til dinner time at 5:00 pm. When family member got there, he/she usually takes resident to the bathroom and out to the car. On this day the family member could not get resident up...it took him/her and certified staff G to get resident to the car and family member asked certified staff G why resident was so out of it and certified staff G told family member he/she	S3028		

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S3028	Continued From page 8 had given his/her medications late." Interview on 3-26-15 at 11:23 am with certified staff G confirmed he/she was working on 3-21-15. Stated resident #110's family member dropped resident off around 6:30 am or 6:45 am. Resident had usual Seroquel about 7:30 or 8:00 am. Stated resident was "always on the go...wanderer, but doesn't bother anyone. About 3:00 pm, finally crashed and took a nap in the sunroom." Around 4:00 or 4:30 pm took resident #110 to the bathroom, walked with resident from the restroom to the dinner table. Family member came to pick resident up around 5:30 or 6:00 pm. Certified staff G stated he/she helped resident out to the car. Stated resident "was tired, but I didn't think anything about it. Next day he/she came back in at 100%." Stated he/she gave resident his/her Seroquel at 8:00 am. Confirmed he/she gave the Seroquel on time at 8:00 am, stated resident was "mainly through his/her meal (breakfast)...he/she usually eats pretty fast...so it was towards the end of his/her meal when I gave it. He/She will sit and drink coffee." Review of corporate findings on 3-26-15 stated: "...investigation not completed. Spoke with certified staff G and he/she reported that he/she spoke with operator on the telephone that night, but (operator) did not tell certified staff G to give any kind of medication. (Certified staff G) did report that he/she gave resident #110's prescribed medication late that day and that may be why (resident) was acting differently." The findings were signed by administrative staff J and lacked documentation of the allegation of abuse/neglect being reported to the department. For resident #110, the operator failed to ensure an allegation of abuse or neglect was reported to	S3028		

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S3028	Continued From page 9 the department within 24 hours.	S3028		
S3120 SS=D	26-41-203 (b) Adult Day Care Services (b) Adult day care services. Any administrator or operator of an assisted living facility or residential health care facility may provide adult day care services to any individual who meets the facility ' s admission and retention criteria and receives services less than 24 hours a day if the administrator or operator ensures that all of the following conditions are met: (1) Written policies are developed and procedures are implemented for the provision of adult day care services.(2) All the requirements for admission of a resident to an assisted living facility or residential health care facility are met for an individual admitted for adult day care services. (3) At least 60 square feet of common use living, dining, and activity space is available in the facility for each resident of the facility and each resident receiving adult day care services. (4) The provision of adult day care services does not adversely affect the care and services offered to other residents of the facility. This REQUIREMENT is not met as evidenced by: KAR 26-41-203(b) The facility reported a census of 23 residents and 1 day care resident. The sample included 3 residents and 2 focus review residents. Based on record review and interview for all day care residents, the operator failed to ensure written policies are developed and procedures are implemented for the provision of adult day care	S3120		

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S3120	Continued From page 10 services. Findings included: - Review of facility "Policies and Procedures" notebook revealed the notebook lacked written policies and procedures for the provision of adult day care services. - Interview on 3-26-15 at 11:19 am with administrative nurse A reviewed the notebook and confirmed it lacked written Policies and Procedures specific for provision of adult day care services. For all day care residents, the operator failed to ensure written policies are developed and procedures are implemented for the provision of adult day care services.	S3120		
S3155 SS=G	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. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 23 residents and one day care resident. The sample included 3	S3155		

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S3155	Continued From page 11 residents and one focus review resident. Based on observation, record review and interview for 1 (#109) of 3 sampled residents, the administrator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident when the licensed nurse failed to provide or coordinate interventions to address this cognitively impaired resident ' s risk for falls. Resident #109, who had a history of falls, fell on 10-9-14 and suffered an injury to the head, fell multiple times on 10-9-14 and on 10-21-14 was diagnosed with a fractured humerus. Findings included: - Record review for resident #109 revealed admission on 12-31-13 with diagnoses Alzheimer ' s Dementia (other diagnoses from hospital record included Hypertension and Osteoarthritis). The functional capacity screen (FCS) dated 12-31-13 recorded resident required physical assistance with bathing, dressing, and walking/mobility; supervision with toileting, transfers and eating; and unable to perform management of medications/treatments. Occasionally incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks: falls/unsteadiness (" Fall at home with hospitalization prior to admit. Exhibits unsteadiness when walking. ") Updated on 1-6-14 " resident oriented to self, time, room, and place " (note: resident had urinary tract infection at admission affecting cognition). The negotiated service agreement/health care service plan (NSA/HSP) dated 12-31-13 recorded the following services:	S3155		

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S3155	Continued From page 12 Bathing: shower assist 2 times per week. Toileting: stand by assistance, staff will assist on and off as needed. Staff will apply briefs at bedtime and as needed. Mobility/Walking: ambulate with walker, staff will monitor in hallway. Wheelchair for periods of pain. Staff to assist with walker or wheelchair. Dressing: staff will assist with dressing and clothing selection. Transferring: Stand by assistance as needed. Sleep Cycle Support: Staff will check on resident every 2 hours at night. Additions to NSA/HCSP: 1-21-14: " Fell in room, fractured femur. Educated resident to use call light and walker. Resident verbalized understanding of instruction. " 4-4-14: " Fell in room. Reviewed previous instruction on using call light and waiting until help arrives. Educated and reminded resident to wear brief and call for assistance changing and wear shoes/slippers at all times when ambulating. " 4-28-14: " Found sitting up on floor in front of refrigerator in resident ' s room. Re-educated on call light use, wait until staff arrives. Use walker, wear shoes. " 5-17-14: " Resident slipped and fell leaving bathroom in room. Resident re-educated to use call light, use walker, depends and wear slippers. " 10-6-14: " Resident fell trying to go down the hallway in front of doorway. Order for physical therapy evaluation. " The NSA/HCSP lacked further interventions to address resident ' s fall risk. Nurse ' s Notes documented a fall on 1-21-14 with a fractured femur, 3-16-14, 4-4-14, and	S3155		

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S3155	Continued From page 13 4-28-14 with skin tears and a fall on 5-16-14 with skin tear and abrasion. No falls documented from 5-6-14 to 10-6-14. Nurse ' s notes documented the following: 10-6-14 at 3:50 pm: " Resident fell. (Another resident) heard resident fall and went to tell nurse ...did not see him/her fall just heard. Resident was found in doorway of room sitting on the floor. Resident was bleeding from head. Emergency Medical Services was notified to take resident to hospital for further evaluation. Resident had full range of motion. Complained of pain in right arm and elbow pain rated a 9 on scale ...resident stated, " I was trying to go down the hallway. " " Signed by licensed staff C. - Emergency Room report stated resident seen for " fall/laceration on left side of head. " CT scan showed " no evidence of intracranial bleed. " X-ray of pelvis/right hip revealed " no acute abnormality. " Resident ' s family member given education materials and follow up instructions for " Hypertension - controlling high blood pressure; Hematoma; Facial Contusion; and Scalp Contusion - with instructions to be awakened every 2 hours, use of ice pack and signs/symptoms of concussion to watch for. " 10-7-14 at 9:00 pm: " Resident returned with (family member). Very confused. Resident taken to bathroom and put to bed. " Signed by certified staff F. The NSA/HCSP lacked interventions to address the resident ' s increased risk for falls and change in cognition. 10-9-14 at 3:00 pm and 8:00 pm: " Resident	S3155		

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S3155	Continued From page 14 came to breakfast and lunch with aide of walker. Ate 75% at both meals. Skin tear on right arm from fall previously was bleeding and in need of attention. Steri-strips and dressing applied at this time. Resident was very agitated and not following directions well. This progressed through all of 2nd shift. This resident is high fall risk and was found on the floor 2-3 times today. Won ' t stay down and can ' t remember what he/she got up for. " Signed by certified staff E. - The record lacked a description of the date and time of the falls and nursing assessment of the resident. The NSA/HCSF lacked interventions to address the residents risk for falls and behavior change. 10-21-14 at 2:45 pm: " Nurse contacted (family member) about resident ' s change in condition. (Family member) will pick up resident to take to hospital ... " Signed by licensed staff C. Hospital report: x-ray of right shoulder dated 10-21-14: " Oblique fracture proximal humeral shaft with distal fracture fragment completely displaced anteriorly with 2 cm overriding. Chronic degenerative changes at the right shoulder with increased superior subluxation of humeral head and fracture laterally end of deformed right clavicle and medial end of deformed acromion process of scapula. The record lacked description of the resident ' s change in condition, and documentation of any incident or accident that may have resulted in the fractured humerus. The record further lacked documentation of the resident ' s return to the facility. Note on 10-25-14 at 10:00 pm stated resident . . " complained of right arm hurting most of the day though wouldn ' t keep it in sling	S3155		

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S3155	Continued From page 15 or immobilized. Resident kept trying to stand up get out of wheelchair or recliner at all times ... " Signed by certified staff E. Interview with operator on 3-26-15 at 2:32 pm and 3-30-15 at 2:40 pm stated the " change in condition " documented in the record on 10-21-14 was " he/she was out of it in the head, not making much sense and talking about dead people. " Operator stated he/she couldn ' t remember resident having a fall on that day, he/she did not know how the resident ' s arm came to be fractured and failed to perform an investigation. Confirmed resident was a high fall risk. Further confirmed the health service plan lacked instructions to staff for use of a sling, keeping the arm immobilized or care while the arm healed. Interview on 3-26-15 at 1:39 pm with administrative nurse A confirmed the resident was a high fall risk and the NSA/HCSP lacked documentation of an appropriate health care service plan specific to meet the resident ' s increased risk of falls as the resident continued to experience falls. Administrative A further stated because the resident was confused at times, reminders to use the call light and wait for assistance were inappropriate interventions. For resident #109, 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 when the licensed nurse failed to provide or coordinate interventions to address this cognitively impaired resident ' s risk for falls. Resident #109, who had a history of falls , fell on 10-9-14 and suffered an injury to the head, fell multiple times on 10-9-14 and on	S3155		

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S3155	Continued From page 16 10-21-14 was diagnosed with a fractured humerus.	S3155		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(3) The facility reported a census of 23 residents and one day care resident. The sample included 3 residents and 2 focus review residents. Based on observation and interview, the licensed nurse failed to ensure over the counter medications shall be labeled with the resident's full name. Findings included: - Observation of medication room during tour on 3-25-15 at 12:29 pm revealed a cabinet labeled "Staff Stock Meds" with the following medications labeled as "stock":	S3211		

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S3211	Continued From page 17 Dulcolax tablets 5 mg (milligrams) 1 opened box. 1 open bottle of Benefiber. 1 open bottle of Milk of Magnesia. 2 bottles Fleet Enemas, Unopened. Ipratropium Bromide and Albuterol Sulfate inhalation solution - one large ziplock baggie of 17 pouches with 5 vials per pouch. All medications lacked a resident's name. Interview on 3-25-15 at 12:29 pm with operator and certified staff K confirmed the containers of over the counter medications lacked resident names and stated the medications were not used by staff. The licensed nurse failed to ensure all over the counter medications were labeled with the resident's full name.	S3211		
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 23 residents and one day care resident. The sample included 3 residents and 2 focus review residents. Based on record review and interview for 2 (#110, #116) of	S3261		

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S3261	Continued From page 18 3 sampled residents and 1 (#115) of 2 focus review residents, the operator failed to ensure 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. Findings included: - Record review for resident #110 revealed admission on 1-12-15 with diagnosis of Dementia. The functional capacity screen dated 1-12-15 recorded resident required physical assistance with bathing and management of treatments; independent with dressing, transfers, walking/mobility and eating; and unable to perform management of medications. The negotiated service agreement/health care service plan dated 1-12-15 recorded services for staff to provide reminders for toileting, meals and activities; and "Health Care Services: Medication Assistance: staff to set up, administer and store all medications." Review of resident's record on 3-25-15 and 3-26-15 revealed the record lacked documentation of resident's health, medical or behavioral status. Interview on 3-26-15 at 11:00 am with administrative nurse A confirmed the record lacked documentation of nurse's notes, vital signs, admission notes or any assessments or description of resident's behaviors. For resident #110, the operator failed to ensure documentation of all incident, symptoms and other indications of illness or injury including the date, time of occurrence, action taken and results of the action.	S3261		

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S3261	Continued From page 19 - Record review for resident #115 revealed admission on 6-10-11 with diagnoses Dementia, Hypertension, Macular Degeneration and Thrombocytopenia. The functional capacity screen dated 6-11-14 recorded resident required physical assistance with bathing and management of medications/treatments; supervision with dressing, toileting and walking/mobility; independent with transfers and eating. The negotiated service agreement dated 6-11-14 recorded services for assistance with bathing, assist with dressing/undressing, monitoring of walking/mobility and medication assistance. Staff to remind/encourage to use toilet and provide reminders for meals and activities. Nursing notes dated 5-23-14 stated, "Resident was up most of this night. Resident thought there was a man in his/her room. This aide helped resident look for mystery man then settled resident in bed. Resident then began to complain of severe headache remainder of night and requested going to the hospital. Signed by certified staff L. The record lacked documentation of follow up by a nurse including assessment of resident's symptoms and notification of physician and responsible party. Interview on 3-26-14 at 1:20 pm with administrative nurse A confirmed the record lacked documentation of assessment by a nurse when the resident complained of a severe headache and requested to go to the hospital; and further confirmed lacked documentation of notification of physician and responsible party.	S3261		

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S3261	Continued From page 20 For resident #115, the operator failed to ensure documentation of all symptoms and other indications of illness including action taken and results of the action when the resident complained of a severe headache and requested to go to the hospital. - Record review for resident #116, revealed admission on 3-11-11 with diagnosis of Alzheimer's Dementia. The functional capacity screen dated 3-11-15 recorded resident required physical assistance with bathing; supervision of dressing, toileting, walking/mobility and eating; independent with transfers; and unable to perform management of medications/treatments. Cognition: problems with short term memory; memory/recall and decision-making. The negotiated service agreement dated 3-11-15 recorded services for staff assistance with bathing, dressing/undressing; staff to provide reminders to use walker and medication assistance included staff set up and administration of medications. Record review revealed communication with physician's office on 3-23-15 stated, "Resident's arm have a number of skin tears that are infected. Was wondering if doctor would give him/her some antibiotic. They are very bad! If you call me when the order is ready, I will pick it up or call it into pharmacy." Signed by certified staff F. The record lacked documentation of where the skin tears came from, documentation of an	S3261		

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S3261	Continued From page 21 assessment of resident's arm for signs of infection and follow up of skin tears by a licensed nurse. Interview on 3-30-15 at 3:30 pm and 3-31-15 at 3:08 pm with administrative nurse A confirmed the record lacked documentation of where the skin tears came from and documentation of a physical assessment and follow up by a licensed nurse. For resident #116, the operator failed to ensure documentation of an injury including date, time of occurrence, action taken and results of the action when the resident experienced skin tears with signs of infection.	S3261		
S3420 SS=E	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 hoses or tubing can be attached. (B) Water distribution systems shall be	S3420		

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S3420	Continued From page 22 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)(2)(B) The facility reported a census of 23 residents and one day care resident. The sample included 3 residents and 2 focus review residents. Based on observation and interview for all residents, the operator failed to ensure the temperature of hot water ranged between 98 degrees Fahrenheit and 120 degrees Fahrenheit at sinks in resident use areas. Findings included: - During tour of facility accompanied by operator on 3-25-15 at 1:10 pm revealed water	S3420		

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S3420	Continued From page 23 temperature in public restroom #1 54.3 degrees Fahrenheit and in public restroom #2 at 69.6 degrees Fahrenheit. Both temperatures confirmed by operator. Interview on 3-26-15 at 4:30 pm with administrative staff J stated recheck of the hot water temperature revealed public restroom #1 was 54.0 degrees Fahrenheit and public restroom #2 temperature was 100.0 degrees Fahrenheit. Interview on 3-26-15 around 4:45 pm with operator and plumber stated adjustments had been made to the hot water tanks to raise the temperature in the public restrooms. For all residents, the operator failed to ensure the hot water temperature in public restrooms #1 and #2, resident use areas, ranged between 98 degrees Fahrenheit and 120 degrees Fahrenheit.	S3420		