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	N087075	A. BUILDING: _____ B. WING _____	R-C 09/12/2017

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{S 000}	INITIAL COMMENTS The following citations represent the findings of revisit 6HPT12 with complaints #118595, #119599, #119698, #119407, and #120190 at the above named facility on 8-24-17, 8-28-17, 8-29-17, 8-30-17, 8-31-17, 9-1-17, 9-5-17, 9-6-17, 9-7-17, 9-11-17 and 9-12-17.	{S 000}		
S 110 SS=D	26-39-103 (c) NOTICE OF RIGHTS AND SERVICES (c) Notice of rights and services. (1) Before admission, the administrator or operator shall ensure that each resident or the resident's legal representative is informed, both orally and in writing, of the following in a language the resident or the resident ' s legal representative understands: (A) The rights of the resident; (B) the rules governing resident conduct and responsibility; (C) the current rate for the level of care and services to be provided; and (D) if applicable, any additional fees that will be charged for optional services. (2) The administrator or operator shall ensure that each resident or the resident ' s legal representative is notified in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care. This STANDARD is not met as evidenced by: KAR 26-41-103(c)(2) The facility identified a census of 83 residents. The sample included 18 residents. Based on	S 110		

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

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S 110	Continued From page 1	S 110		

record review, interviews, and observations for confidential resident(s) sampled, the administrator failed to provide resident's legal representative notification in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The administrator charged the resident's legal representative for bed bug extermination without giving a 30 day notice in writing.

Findings included:

Review of confidential resident's negotiated service agreement and admission agreement lacked description in writing stating the responsible party will be billed for pest control or treatment of bed bugs.

Confidential interview on 8-30-17 stated resident was billed for an exterminator who the administrator sent to resident's room to treat for bed bugs without notice from the administrator until after treatment of room was completed.

Interview on 8-29-17 at 5:15 p.m. with administrator and regional manager, asked if he/she billed residents for treatment of bed bugs. The administrator stated he/she had billed residents in the past as he/she felt bed bugs were brought into the facility. The administrator stated he/she charged three residents' responsible parties for treatment of bed bugs.

For confidential resident(s), the administrator failed to provide resident's legal representative notification in writing of any changes in charges or services that occur after admission when the administrator charged legal representative for bed

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S 110	Continued From page 2 bug extermination without giving a 30 day notice in writing of the change in services.	S 110		
{S3026} SS=J	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)(B) The facility identified a census of 83 residents. The sample included 18 residents. Based on record review, interviews, and observations for 1 (#1000) of 14 residents sampled, the administrator failed to ensure no resident shall be subjected to neglect when facility staff failed to conduct visual checks after 10 p.m. on resident #1000 and he/she was locked outside in a secured courtyard from approximately 8:00 p.m. until 7:00 a.m. with no lights overnight. Resident found lying on patio two cushion love seat at 7:00 a.m. These failures place resident #1000 in immediate jeopardy for harm, injury, or death. Findings included: - Record review for resident #1000 revealed an admit date of 11-30-15 with diagnoses of	{S3026}		

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{S3026}	Continued From page 3 dementia, depression, hypertension, and atopic dermatitis. The functional capacity screen dated 12-1-16 (re-admit from hospital) recorded resident required supervision with transfer, walking/mobility, physical assistance with bladder incontinence, experienced poor memory recall, impaired vision/hearing, impaired decision making, and falls/unsteadiness. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCP) dated 12-1-16 recorded escort resident to and from meals, remind of meal times, provide redirection to room at times of confusion, occasional verbal cueing and reminders to use walker/cane when ambulating, stand by assistance for mobility, resident has fallen last 90 days, provide stand by assistance for transfer, resident incontinent of bladder, cue or remind resident frequently, two hour checks, cue /remind, and provide stand by assistance. Night time provide stand by assistance with undressing/night time care. . . Judgment is frequently poor; needs supervision. . . . 2-19-17 Staff to make sure resident has walker within reach in evenings and at bed time due to fall. Interview on 8-29-17 at 5:30 p.m. with administrator stated, "(resident #1000) moved from assisted living to memory care unit on 7-30-17." The wellness notes lacked documentation that indicated resident was moved from assisted living to memory care unit on 7-30-17.	{S3026}		

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{S3026}	Continued From page 4	{S3026}		

The wellness notes recorded the following:

8-22-17 at 7:00 a.m. "It was reported to this nurse by staff that resident was brought inside from courtyard. Resident was given breakfast and then went to room to watch television. This nurse completed a head to toe assessment with the following results: skin pale, warm, and dry. Resident has dry patchy areas to bilateral upper arms. . .No noted red areas to back or abdominal areas. On right shoulder top portion close to neck is a moveable soft raised area. No complaint of discomfort. Resident stated doctor aware of it and it was a fatty mass. Vital signs Temperature (T) 98.9, Blood Pressure (B/P) 148/70 Pulse (P) 52, Respirations (Resp) 18. Oxygen Saturation (O2 sat) 95%. Denies having pain and or discomfort. Resident requested a shower. This nurse instructed staff to assist resident with a shower. Signed licensed nurse L.

The record lacked further documentation.

8-24-17 at 2:15 p.m. observed resident #1000 sitting on recliner in room with dog on lap. Noted when door opened unable to visually see half of bed next to wall unless walked into room. Resident stated was fine and no complaints of discomfort. While resident was petting dog asked if he/she slept all night out in the court yard recently. Resident stated did not remember anything about that.

On 8-24-17 at 3:30 p.m. licensed nurse A provided copies of written statements dated 8-22-17 for investigation of resident #1000 being locked outside in memory care unit court yard all night 8-21-17 thru 8-22-17 until 7:00 a.m.

Written statement from certified staff V recorded:

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{S3026}	Continued From page 5 After my shift on 8-21-17, I forgot to tell the oncoming shift at 10:00 p.m. that (resident #1000) was sitting out in the memory care unit (MCU) court yard. When I went over to relieve my coworker, he/she told me that the resident was out in the court yard with his/her dog. I did offer him/her water with medications and throughout the rest of my shift (until 10:00 p.m.). I also did frequent visual checks on resident before my shift ended at 10:00 p.m. I was also by myself in MCU 1 after coming over from MCU 2. Written statement from certified staff BB recorded: "Last night second shift told us everyone was in bed and we went in and scanned bed (resident #1000) appeared to be in. The television (TV) was on so we assumed resident was asleep and didn't want to wake resident up. Normally when resident in room the television is on and when resident leaves room he/she turns television off. When morning came and we seen (resident #1000) was outside. During the night, no lights are on [outside] and it is pitch dark out so we couldn't see resident or anyone outside. From now on I will go into the resident's rooms and make sure resident it in the bed." Written statement from certified staff AA recorded: "When I got on shift I did my rounds with certified staff V and he/she told me everyone was in bed and changed. I heard resident #1000's TV on so I thought he/she was in room because when in room leaves TV on and turns off when leaves room. I was told he/she was in bed. Working with resident in the past I knew that he/she would leave TV on all night so when I cracked the door slightly in case dog was not in kennel I saw the TV was on and thought resident was asleep. From now on I will know to do my	{S3026}		

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{S3026}	Continued From page 6	{S3026}		

visual checks on everyone and make sure they are safe and in bed."

Written statement from certified staff H recorded: "At 7:00 a.m. on 8-22-17 I seen (resident #1000) outside sleeping on the couch (outdoor two cushion love seat) out in the court yard. Me and certified staff AA woke resident up and took him/her to his/her room."

Interview on 8-28-17 at 3:45 p.m. with certified staff M stated did thirty minute checks on resident #1000 and identified on computer (Care Tracker) where certified staff checked off visual check every thirty minutes in the computer for 8-21-17 and 8-22-17.

Wunderground.com recorded the temperature at 8 p.m. on 8-21-17 as 88 degrees Fahrenheit (F) with an average temperature of 77 degrees F throughout the night and 74 degrees at 7 a.m. on 8-22-17.

On 8-24-17 at 3:15 p.m. observed courtyard for MCU 1 and MCU 2. The courtyard had a secured coded entry/exit door on each unit that went out to gated courtyard. There was a two cushion patio love seat by each door. The lights in court yard did not work.

Interview on 8-24-17 at 3:15 p.m. with certified staff X, V, F, and BB all stated the lights outside did not work and unable to see anything outside glass doors/windows after dark. The staff further stated the lights have not worked for a long time.

Interview on 8-28-18 at 2:30 p.m. with licensed nurse L stated came to work on 8-22-17 at 5:30 a.m., got report from certified staff X due to no nurse on duty on the night shift from 10:00 p.m. to

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{S3026}	Continued From page 7 5:30 a.m. Made sure staff assignments completed, got blood sugars and was notified to go to MCU 1. When he/she arrived in MCU 1 certified staff AA and BB stated resident #1000 slept outside in courtyard all night. Staff reported they were told all residents were in bed or rooms. They stated the stuffed monkey at foot of bed in resident #1000's room looked like resident's feet. Licensed nurse L assessed resident and stated resident said he/she was watching the stars outside. Resident was warm to touch and vital signs taken. For resident #1000, the administrator failed to ensure no resident shall be subjected to neglect when facility staff failed to conduct visual checks after 10 p.m. on resident #1000 and he/she was locked outside in a secured courtyard from approximately 8:00 p.m. until 7:00 a.m. with no lights overnight. Resident found lying on patio two cushion love seat at 7:00 a.m. These failures place resident #1000 in immediate jeopardy for harm, injury, or death. The jeopardy was removed on 8-24-17 when the administrator provided the following plan: 1. As of 8-22-17 staff are making sure they physically see each resident in memory care area at least every two hours. Starting 8-24-17 we will be documenting the 2 hour visual checks on the visual checks form (copy of form provided) 2. As of 8-22-17 nurses and aides assigned to memory care area are to make walking rounds during report and make visual contact with each resident and this will be recorded on the visual check sheet 3. As of 8-24-17 the code for outside courtyard was placed on top of the keypad to get back into the building 4. Residents from memory care will be monitored	{S3026}		

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{S3026}	Continued From page 8 while in the courtyard independently at least every 30 minutes on the memory care courtyard visual checklist form (copy of form provided) 5. Staff involved in 8-21-17 situation were interviewed and educated on expectations of making rounds and visual checks on each resident in memory care and will be presented in writing by 8-26-17. 6. Staff are being education on #'s 1, 2, 3 and 4 above prior to working next shift. Will have each staff education on these training points verbally or in writing by midnight Saturday 8-26-17.	{S3026}		
S3155 SS=J	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 identified a census of 83 residents. The sample included 14 residents. Based on record review, interviews, and observation for resident 1 (#1000) of 14 residents sampled, the administrator failed to ensure the implementation of the plan provided to the department on 6-28-17 to address the resident's risk for elopement. The	S3155		

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administrator further failed to ensure the licensed nurse provided or coordinated Health Care Services to address resident #1000 elopement risk. The licensed nurse failed to implement interventions to address the resident's elopement risk while in assisted living. The licensed nurse further failed to implement a plan to address the resident's elopement risk after resident moved to memory care on 7-30-17 and was allowed to ambulate to main dining room in assisted living for meals where he/she was left unattended at times. These failures placed resident in immediate jeopardy for harm, injury, or death. For resident 1 (#1225) of 14 residents sampled, the administrator further failed to ensure the licensed nurse provided and coordinated health care services to address the resident's fall risk.

Findings included:
- Record review for resident #1000 revealed an admit date of 11-30-15 with diagnoses of dementia, depression, hypertension, and atopic dermatitis.

The functional capacity screen dated 12-1-16 (re-admit from hospital) recorded resident required supervision with transfer, walking/mobility, physical assistance with bladder incontinence, experienced poor memory recall, impaired vision/hearing, impaired decision making, and falls/unsteadiness.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCP) dated 12-1-16 recorded escort resident to and from meals, remind of meal times, provide redirection to room at times of confusion, occasional verbal cueing and reminders to use walker/cane when ambulating, stand by assistance for mobility, resident has fallen last 90 days, provide stand by assistance

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for transfer. . Resident is generally oriented but may need occasional cueing to find direction and remember information. Judgment is frequently poor; needs supervision. "N/A for pet management." (Resident has a small dog in room.) 2-19-17 Staff to make sure resident has walker within reach in evenings and at bed time due to fall.

The amended NSA dated 12-6-17 recorded, "resident has one small dog. Staff to help remind resident to take dog out and help in mornings and evening to take out."

The written plan for resident from elopement on 6-27-17 provided to the Department recorded: Resident will have one on one companion from 6:00 p.m. to 6:00 a.m. starting 6-27-17 until Wednesday 7-5-17 with fifteen minute visual checks to continue while the one on one is not here. Motion sensor to be set on apartment door from 6:00 a.m. to 6:00 p.m. On 7-5-17 will reassess resident since resident will have completed antibiotic for UTI and move the one on one to 5:00 p.m. to 9:00 p.m. An agency was chosen by family for companion care. Visual checks will continue when one on one is not here. Motion sensor on apartment door will be set from 7:00 p.m. to 6:00 a.m. starting 7-5-17. Resident is next to transition to memory care.

The NSA/HCS plan lacked documentation of these interventions.

The record lacked documentation of 15 minute checks, companion care or motion sensor.

The record contained a faxed order to inform physician that resident has moved from (assisted

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living) to memory care unit on 7-28-17

The wellness notes lacked documentation that indicated resident was moved from assisted living to the memory care unit.

On 8-24-17 at 2:05 p.m. observed resident #1000 sitting in recliner in room with dog on lap. He/she stated does not remember leaving facility. Further stated he/she liked watching TV and to walk around. Observed walker across the room. Resident stated he/she takes care of self and did not need any assistance.

Interview on 8-24-17 at 5:00 p.m. with certified staff F stated resident #1000 goes to assisted living dining room for meals. Certified staff open MCU door and resident walks straight down hall to dining room. The kitchen staff will call staff in MCU when resident is ready to leave.

Interview on 8-28-17 at 12:00 noon with dietary aide G stated resident #1000 comes to assisted living dining room for meals and sits with a friend. Resident #1000 ambulates from MCU 1 to this dining room and the staff here in main dining room calls MCU 1 staff to come and get resident when he/she is finished. Dietary aide G stated he/she is not in main dining room at all times because has to get food ready and deliver to other residents. Staff goes in and out of dining room getting food for residents.

Confidential interview on 8-31-17 stated (resident #1000) eats in the assisted living dining room with his/her friends.

Confidential interview on 8-28-17 at 2:30 p.m. stated resident eats meals in assisted living dining room. Kitchen staff will call when resident

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is through eating. The kitchen staff will call when resident ready to come back to MCU. Confidential staff unable to locate in NSA/HCS with interventions to instruct staff to take resident to assisted living dining room or who will monitor resident while in dining room and confirmed resident at risk for elopement.

Interview on 8-28-17 at 1:10 p.m. with certified staff H stated resident #1000 usually goes to assisted living dining room to eat meals but did not want to go today and will be eating in MCU 1.

Interview on 8-28-17 with licensed nurse A stated and confirmed unable to locate any documentation that indicated a plan was implemented after resident eloped on 6-27-17 and confirmed no interventions for elopement were put in place while resident resided in assisted living. Licensed nurse A was not aware resident #1000 went to assisted living dining room for meals. Licensed nurse A confirmed the NSA/HCS lacked interventions for residents to go to assisted living for meals and who is to observe resident to ensure he/she does not leave the facility.

Interview on 8-28-17 at 5:45 p.m. with administrator stated was not aware resident #1000 left MCU to go to assisted living to eat meals. Administrator asked for a written plan to ensure resident does not elope as identified at high risk for elopement and eloped on 6-27-17.

Interview on 8-29-17 at 5:30 p.m. with administrator stated, "(resident #1000) moved from assisted living to memory care unit on 7-30-17."

For resident #1000, the administrator failed to

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ensure the implementation of the plan provided to the department on 6-28-17 to address the resident's risk for elopement. The administrator further failed to ensure the licensed nurse provided or coordinated Health Care Services to address resident #1000 elopement risk. The licensed nurse failed to implement interventions to address the resident's elopement risk while in assisted living. The licensed nurse further failed to implement a plan to address the resident's elopement risk after resident moved to memory care on 7-30-17 and was allowed to ambulate to main dining room in assisted living for meals where he/she was left unattended at times. These failures placed resident in immediate jeopardy for harm, injury, or death.

The jeopardy was removed on 8-29-17 at 2:35 p.m. when the administrator provided a written plan for resident #1000 that recorded the following:

Plan of Action (for resident #1000 reference to eating in Main Dining Room (assisted living dining room).

As of this date, 8-29-17 (resident #1000) will not be eating in the main dining room unless escorted by a family member of his/hers.

- Record review for resident #1225 revealed an admit date of 11-1-14 with diagnoses of dementia, Parkinson's disease, and chronic urinary retention.

The Functional Capacity Screen (FCS) dated 3-3-17 recorded resident independent with toileting, transfer, walking/mobility, eating, bladder

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incontinence (foley catheter), required physical assistance with bathing, dressing, experienced short term memory loss, memory recall, and falls/unsteadiness. Note: FCS not amended with a significant change in condition.

The Negotiated Service Agreement (NSA)/Health Care Service Plan (HCSP) dated 3-3-17 recorded resident has no behavior problems, and independent with ambulation . Resident is orient to time, place and person and remembers information. Resident needs occasional cueing to find directions and remember information at times. No behavioral issues and judgment is good, makes appropriate decisions. For safety/emergency procedure needs supervision, but no physical assistance to evacuate residence. Resident had fall on 4-4-17 and interventions are: family to pick up cane. Resident to use walker and refer to physical therapy. 4-15-17 Fall: faxed doctor for urinalysis order. Fall on 6-17-17, remind to use walker. Fall on 7-1-17, slid out of wheelchair, make sure resident is in recliner and pendant on resident.

Fall risk assessment documented "If 10 or more points are awarded, a care plan for falls should be initiated" and recorded the following:
- 7-1-17 recorded total points 16.
- 7-12-17 recorded total points 15.
- 7-14-17 recorded total points 13.

The Wellness Notes recorded the following falls:

7-11-17 at 3:15 p.m. This nurse was notified that resident needed assistance in his/her apartment. I entered apartment and observed resident lying on the floor on left side with head towards the couch and legs out. Resident denied pain and stated did not use call pendant because he/she

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was just trying to move recliner to couch to sit. . . Resident's last 15 minute visual check was documented at 3:10 p.m. Signed licensed nurse L.

7-14-17 at 2:20 p.m. Observed resident in room on floor with walker next to him/her. Resident unable to say how he/she got on floor and able to move all extremities without difficulty. Housekeeper observed resident on floor when walking by room and notified staff. Signed licensed nurse JJ.

7-17-17 at 8:15 p.m. Observed resident lying on back next to TV stand unable to state what occurred, resident observed with recliner chair still in reclined position. Resident denied hitting head and able to make needs known. Resident has active range of motion without difficulty. Signed licensed nurse JJ.

8-9-17 at 9:15 p.m. This nurse was approached by a visitor of the community stating he/she heard the resident yell for help. This nurse immediately went to resident's room. Upon entering the room the resident was observed sitting on the floor with right arm resting against recliner and left arm resting against couch with legs stretched out in front. Several superficial skin tears on right forearm. . . Resident assisted up off floor with two staff, . . . Signed licensed nurse L.

8-18-17 at 9:00 p.m. Went to give night time medications and found resident on the floor next to bed, denied hitting head, and did not use call light. . . . Assisted resident up to wheelchair with two staff assistance. Resident assisted to bed. Signed licensed nurse KK.

8-26-17 at 2:20 a.m. resident was found on floor

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S3155	Continued From page 16 in hallway by staff lying on left side with foley in trash can. Resident stated was looking for toilet and spouse. Resident concerned about spouse and can't find him/her. Resident assessed with good range of motion, no redness or skin tears. Resident denied hitting head or having pain. Medical care provider notified of non-injury fall. Interview on 8-31-17 at 3:44 p.m. with certified staff I stated resident is a physical assist with activities of daily living and really confused today. Resident is on every 15 minute checks and stated it is extremely difficult when in another resident room giving a shower. We have 4 staff working this evening. Has reported his/her concerns to licensed nurse B regarding level of resident care needs and staffing. Interview on 8-31-17 at 4:04 p.m. with licensed nurse L stated resident can't transfer by self, and required walking with assistance. Reviewed what is recorded on functional capacity screen for activities of daily living and he/she confirmed resident had a significant change in condition. For resident #1225 who experienced 6 unwitnessed falls from 7-11-17 to 8-26-17, the administrator failed to ensure the licensed nurse provided and coordinated services to address the resident's fall risk.	S3155		
S3265 SS=F	26-41-104 (a) Disaster and Emergency Preparedness (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location.	S3265		

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This REQUIREMENT is not met as evidenced by:
KAR 26-41-104(a)

The facility identified a census of 83 residents. The sample included 18 residents. Based on record review, interviews, and observations for all residents, the administrator failed to ensure the provision of a sufficient number of staff members to take resident who would require assistance in an emergency or disaster to a secure location when he/she failed to document the ability to safely evacuate residents with the least number of staff on duty.

Findings included:

- On 8-28-17 at 12:32 requested a copy of last emergency evacuation to a safe secure location from the administrator.

On 8-29-17 at 1:25 p.m. received a copy of monthly fire drill reports from the administrator.

Monthly fire drill reports documented:
6-28-16 at 6:30 a.m. evacuation drill lacked time it took to complete the evacuation and location of where residents were taken. The in-service sheet identified 8 staff participated.

6-28-16 at 1:30 p.m. evacuation drill lacked time it took to complete the evacuation and location where residents were taken. The in-service sheet identified 17 staff participated.

6-28-16 at 2:30 p.m. evacuation drill lacked time it took to complete the evacuation took and location

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where residents were taken. The in-service sheet identified 12 staff participated.

8-30-16 at 4:00 p.m. second shift evacuation drill completed in nine minutes and thirty-five seconds with the assistance of 14 employees. The evacuation drill lacked documentation of where residents were taken. The comments/scenario section was blank.

6-26-17 at 1:30 p.m. first shift evacuation drill completed in eleven minutes and thirty-five seconds with assistance of 15 staff. The monthly fire drill lacked documentation of where resident were taken.

On 8-31-17 at 6 p.m. the administrator provided an additional evacuation drill that documented:

10-24-16 at 2:21 p.m. Monthly fire drill completed in fourteen minutes and fifty-one seconds. The comments section of the form stated "used 6 staff members to simulate a 3rd shift staff. 1st shift stayed for evac training". A document titled "Group Training Sign-In" in-service sheet with no date, time or description of the training was provided with the Monthly Fire Drill Report form and contained signatures of 19 staff.

The resident roster provided on 8-24-17 at 4:10 p.m. from licensed nurse A identified 83 residents. Three residents identified as two person transfer and 54 residents experienced impaired cognition.

Interview on 8-28-17 with certified staff M identified 10 residents on the resident roster as two person transfers.

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S3265	Continued From page 19 Interview on 8-31-17 at 1:00 p.m. with licensed nurse L stated resident roster was not completed correctly for two person transfer and identified 10 residents as two person transfers. Interview on 9-5-17 with maintenance director stated he/she had not conducted an evacuation drill with only 4 or 5 staff on duty. Review of time records from 8-13-17 through 8-27-17 show 9 of the 15 days with only 4 or 5 staff on duty for 5 to 12 hours each day. For all residents, the administrator failed to ensure the provision of a sufficient number of staff member to take resident who would require assistance in an emergency or disaster to a secure location when he/she failed to document the ability to safely evacuate residents with the least number of staff on duty.	S3265		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards;	S3305		

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S3305	Continued From page 20 (4) providing sanitary conditions for food service; (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 (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-207(a) The facility identified a census of 83 residents. The sample included 18 residents. Based on record reviews, interviews, and observations for all residents, the administrator failed to ensure the provision of a safe, sanitary, and comfortable environment for all residents related to repeated spread of bed bugs throughout the facility. Findings included: - The following residents were identified by staff and family members as having bed bugs in room and or on residents: #1227, #1228, #1229, #1230, #1122, #1133, #1199, #1221, #1224, #1144, #1155, #1166, #1177, and #1188. These residents are located in assisted living, memory	S3305		

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S3305	Continued From page 21 care unit (MCU) 1 and MCU 2. Interview on 8-29-17 at 9:20 a.m. with family member stated he/she first learned resident had bed bugs in room when administrator sent an email requesting family member to bring a mattress cover. Family member was not notified furniture was thrown away due to bed bugs. Interview on 8-29-17 at 1:30 p.m. with certified staff I stated resident #1224 has bed bugs in room and picked bed bugs off him/her last week. Confidential interview on 8-29-17 at 2:05 p.m. stated and identified numerous bed bug bites on his/her body and stated facility administrator was aware. Interview on 8-29-18 at 4:00 p.m. with licensed nurse B stated he/she was not notified of any resident having bed bugs on them today. Interview on 8-29-17 at 6:45 p.m. with family member stated was informed by staff resident had bed bugs. Administrator aware of bed bugs in facility but has not done anything except initial treatment in April. Telephone interview on 8-29-17 with a family member stated had seen bed bugs in resident's room, took picture and had it confirmed that it was a bed bug. The facility treated the room for bed bugs and then put the same comforter back on the bed without washing the comforter or other clothing in the room. Confidential written statement recorded bugs have been found in resident rooms #1228, #1122, #1133, #1166, #1177, #1227, #1229, and #1199.	S3305		

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S3305	Continued From page 22 Observation of resident #1122's room on 8-29-17 at 1:45 p.m. revealed bottom mattress contained several dark spots with castings of bed bugs. The corner of the mattress had small hole in it. Certified staff Q present and stated found several bed bugs on him/her in the dining room. He/she put large bug in a plastic container and use tape to remove small bugs off resident, called maintenance director who came and got the cup and tape that contained the bugs Certified staff confirmed he/she was not instructed how to provide care and services to resident related possible bed bugs. On 8-29-17 went into resident #1133's room and observed resident sitting in recliner chair. Certified staff GG present. Certified staff pulled covers back on bed and observed five bugs on bottom sheet. Certified staff brought a piece of clear tape and attached bugs to them. Observation of resident's skin revealed four red areas on right side of neck and upper shoulder area. Resident unable to state what happened. Interview on 8-29-17 at 5:00 p.m. with administrator stated treated entire facility first treated on 4-20-17 for bed bugs and provided the invoices from the exterminator that recorded the following: - 4-20-17 the facility was treated - 8-10-17 treated residents #1199; #1133; #1229 rooms. These rooms were located on assisted living and MCU 1. - 8-11-17 second treatment in same rooms. - 8-22-17 treated resident #1224's room. Interview on 8-31-17 with certified staff I stated if	S3305		

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found bed bugs to report to nurse and maintenance director. Residents go to a motel overnight while room is being treated. Certified staff stated did not know if anyone went to room at motel with residents. Bed bugs identified in residents #1122, #1228, #1133, #1177, #1227, #1229 and #1199.

Interview with a family member on 9-5-17 stated the administrator had residents move to a hotel while rooms being treated for bed bugs.

Interview on 8-29-17 at 5:15 p.m. with administrator stated he/she did not have a policy or procedure for bed bugs/pest control and he/she and regional manager are working on that now. Administrator confirmed staff educated to information nurse and maintenance director if they found bugs but had not been educated on procedures to prevent spread of bed bugs.

On 8-30-17 at 1:30 p.m. administrator provided a policy and procedure for, "Bed Bugs- Preventing and Managing Infestations."
Procedures:
1. When a team member finds an insect that they believe to be a bed bug, they are to notify their supervisor or a member of the leadership team immediately. Upon notification, the contracting pest control company is to be notified as soon as possible. The area or room where the bug was seen is to be inspected by the pest control company to confirm if bed bugs are present.

2. The pest control company will take the necessary steps to eradicated the bed bugs.

3. When the room or area is found to have bed bugs present, steps are to be taken by team

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members entering the room or area to make sure that the bed bugs are not spread to other areas of the community.

A. If it at all possible the room is to be quarantined. Arrangements need to be made for the resident to stay at another location until the room has been cleared of bed bugs by the pest control company.

B. Nurse will conduct a head to toe assessment of the resident with the proper documentation and notification to doctor(s) and family.

C. If arrangements cannon be made by the Community or the residents to go to another location, team members are to take the following steps when entering the area:
1. The room or area should only be entered for care or needed services.
2. Nothing is to be removed from the room.
3. Team members are to spray their legs and shoes with bug repellant.
4. Shoe covers are to be worn.
5. Team members are to make sure that they do not brush up against any furniture, to prevent any eggs from being transferred to the team member.
6. When exiting the room or area, the shoe covers are to be removed and placed in a plastic trash bag which is to be tied shut and taken out to the trash.

D. If arrangements cannot be made by the community or the residents to go to another location, team members are to take the following steps with the residents:
1. Mobility assistive devices are to be wiped down with alcohol and stored outside of the rooms.
2. Clothes to be worn for exiting the room are to

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S3305	Continued From page 25 be placed in a dryer on high for a minimum of thirty minutes. Those clothes are then to be taken to the bathroom for the resident to put on. 2. The resident is to shower, or be assisted in the shower, and the clothes from the dryer put on. The room should then be exited. Interview on 8-30-17 with the administrator stated he/she would have all staff in-serviced on procedure for bed bugs by 9-1-17. For all residents, the administrator failed to ensure the provision of a safe, sanitary, and comfortable environment for all residents related to repeated spread of bed bugs throughout the facility.	S3305		