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	N087075	A. BUILDING: _____ B. WING _____	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OXFORD GRAND	3051 N PARKDALE CIRCLE WICHITA, KS 67205

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S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure Survey with complaint investigations 178276, 178445, 184468, and 184997 for the above named assisted living facility conducted on 02/12/24, 02/14/24, and 02/15/24.	S 000		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201 (c)(1) The facility reported a census of 76 residents (R). The sample included three residents and six focused record reviews. Based on interview and record review the operator failed to ensure staff completed a "Functional Capacity Screen" for three (R3, R4, R5) of three sampled residents at least every 365 days. Findings Included: - R3's "Electronic Medical Record" (EMR)	S3081		

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

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S3081	Continued From page 1	S3081		

revealed he moved into the facility on 06/28/21 with diagnosis of dementia.

R3's EMR included "Functional Capacity Screens" (FCS) dated 06/15/22 and 07/06/23, more than 365 days apart.

On 02/15/24 at 01:27 PM Administrative Licensed Nurse B confirmed R3's FCS had not been completed every 365 days.

Review of the "Assessment and Service Plan" policy revised on 10/21/23 revealed an assessment identifying the resident's functional capability will be conducted immediately upon any significant change and no less than once every twelve months.

The executive director failed to ensure designated staff completed R3's FCS at least every 365 days.

- R4's "Electronic Medical Record" (EMR) revealed he moved into the facility on 07/11/22 with a diagnosis of Alzheimer's disease.

R4's EMR and his paper record included only one "Functional Capacity Screen" (FCS) completed on 07/06/22.

On 02/15/24 at 10:08 AM Administrative Licensed Nurse B looked through R4's EMR and paper chart and confirmed he had not had a FCS completed at least every 365 days.

Review of the "Assessment and Service Plan" policy revised on 10/21/23 revealed an assessment identifying the resident's functional

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S3081	Continued From page 2 capability will be conducted immediately upon any significant change and no less than once every twelve months. The executive director failed to ensure designated staff completed R4's FCS at least every 365 days. - R5's "Electronic Medical Record" (EMR) revealed she moved into the facility on 01/05/18 with diagnoses of hemiparesis and diabetes mellitus type II. R5's EMR and paper chart included two functional capacity screens. One completed on 06/15/22 and the other completed on 07/06/23, more than 365 days apart. On 02/14/24 at 01:59 AM Administrative Licensed Nurse B reported per facility policy the FCS are to be completed quarterly and at a minimum at least annually. Licensed Nurse B confirmed R5's FCS had not been completed at least every 365 days. Review of the "Assessment and Service Plan" policy revised on 10/21/23 revealed an assessment identifying the resident's functional capability will be conducted immediately upon any significant change and no less than once every twelve months. The executive director failed to ensure designated staff completed R5's FCS at least every 365 days.	S3081		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate	S3082		

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S3082	Continued From page 3 d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: K.A.R 26-41-201 (d) The facility reported a census of 76 residents(R). The sample included three residents and six focused record reviews. Based on interview and record review, the executive director failed to ensure designated staff completed two (R3 and R5) of three sampled residents "Functional Capacity Screen" accurately to reflect their functional ability and need for health care services. Findings included: - R3's electronic medical record revealed he moved into the facility on 06/28/21 with diagnosis of dementia. R3's FCS dated 07/06/23 identified the resident needed physical assistance with bathing, was independent with dressing, toileting, transfers, mobility and eating. He was not identified at risk for falls/unsteadiness, wandering or having inappropriate behaviors. On 02/12/24 at 11:15 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) were one document.	S3082		

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S3082	Continued From page 4 R3's NSA/HCSP included dated 06/28/22 identified the resident required set up assistance with obtaining clothing from the closet and dresser as well as tying his shoes. It identified he was at risk for falls due to unsteadiness and had obsessive/repetitive behaviors with anxious paranoid or suspicious behaviors. Review of R3's nursing progress notes prior to 07/06/23 included documentation regarding the following concerns: November of 2022 resident fell while walking outside; December of 2022 resident having increased confusion and wandering; April of 2023 resident refusing to shower and verbally aggressive toward staff; May 2023 wife notified of "behaviors", but did not specify what the behaviors were and also in May 2023 resident also had periods of increased difficulty with walking and needed increased assistance. On 02/14/23 at 10:02 AM Certified Medication Aide (CMA) D reported R3 needed cueing and set up assistance with dressing at times and other times he would get up and dress himself. We need to remind him and cue him for showers and sometimes he will want to argue but we give him space and try again later. He walks around independently but has fallen so we just keep an eye on him and if he needs help, we help him. On 02/15/24 at 01:27 PM Administrative Licensed Nurse B compared the NSA/HCSP that has two dates when staff had signed it, 06/28/22 and 05/04/23 but only had one signature of the DPOA with no date. Administrative Licensed Nurse B confirmed that the NSA/HCSP identified	S3082		

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S3082	Continued From page 5	S3082		

the resident needed assistance with dressing and required cueing and set up assistance as well. It also identified he was at risk for falls and had behaviors, all of which should have been identified on his FCS.

The executive director failed to ensure designated staff coded R3's FCS correctly to identify he needed supervision and set up assistance with activities of daily living, had a risk for falls and had problems with wandering and behaviors.

- R5's electronic medical record revealed she moved into the facility on 02/15/18 with diagnoses of hemiparesis and diabetes mellitus type II.

R5's FCS dated 07/06/23 identified she was unable to participate dressing and mobility and that she used a mechanical lift for transfers and wheelchair for mobility.

Observation on 02/14/24 at 09:38 AM resident lay in bed with Hospice staff helping her to get dressed for the day. R5 was able to follow directions to roll from side to side and would grab ahold of the half bed rail to help herself turn. She had contractures in her right hand/wrist and difficulty raising her arms. However, she would start to raise her left arm as the Hospice staff explained what she was doing. At 09:44 AM Hospice aide and Certified Medication Aide (CMA) E came in to transfer the resident from her bed into her wheelchair using the mechanical lift. Staff then took the resident out to the dining room area for exercises.

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S3082	Continued From page 6 On 02/14/24 at 09:54 AM CMA E reported if there is anything that needs opened at the meal, we have to open it for her and sometimes she will need a little help with getting her silverware situated correctly. When getting her dressed she will lean forward, put her left hand in the sleeve of her shirt and try to do as much as she can with her good arm. When changing her in the bed she will roll herself over-using the bed rail to help with changing her. On 02/15/24 at 01:42 PM Administrative Licensed Nurse B reviewed R5's FCS and confirmed it would not have been accurate at the time of completion based on how she does help some with dressing and able to roll in bed and she is mobile to different activities and meals within the facility. The executive director failed to ensure designated staff completed R5's FCS accurately related to dressing and mobility.	S3082		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will	S3085		

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S3085	Continued From page 7	S3085		

receive;
(2) identification of the provider of each service; and
(3) identification of each party responsible for payment if outside resources provide a service.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-202(a)(1)(2)

The facility reported a census of 76 residents(R). The sample included three residents and six focused record reviews. Based on interview and record review the executive director failed to ensure designated staff completed three (R3, R4, R5) residents "Negotiated Service Agreement" to include a description of services the resident received based upon their "Functional Capacity Screen, services actually provided and who provided services.

Findings included:

- R3's "Electronic Medical Record" (EMR) revealed he moved into the facility on 06/28/21 with a diagnosis of dementia.

R3's "Functional Capacity Screen" (FCS) dated 07/06/23 identified the resident needed physical assistance with bathing and was unable to participate in the management of medications or medical treatments. He had impaired cognition and communications, and impaired decision making.

On 02/12/24 at 11:15 AM Administrative

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S3085	Continued From page 8 Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) were one document. R3's NSA/HCSP failed to address who and what services the resident would receive related to medical treatments, impaired cognition, or his impaired communication. On 02/15/24 at 01:35 PM Administrative Licensed Nurse B reviewed R3's NSA/HCSP and acknowledged it did not address services or who provided services for medical treatments. She acknowledged the NSA identified the resident had impaired cognition but did not included services or who would provide the services related to impaired cognition or his impaired communication. The executive director failed to ensure designated staff completed R3's NSA/HCSP to include a description of services the resident would receive and who would provide those services based upon his FCS. - R4's "Electronic Medical Record (EMR) revealed he moved into the facility on on 07/11/22 with a diagnosis of Alzheimer's disease. R4's most current "Functional Capacity screen dated 07/06/22 identified he needed physical assistance with all activities of living including management of medications and medical treatments. It identified he had bladder incontinence, impaired cognition, at risk for falls/unsteadiness, had impaired vision and hearing, impaired decision-making ability and had wandering and inappropriate behaviors.	S3085		

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S3085	Continued From page 9 On 02/12/24 at 11:15 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) were one document. R4's NSA/HCSP failed to address what services he would receive and who provided those services related to medical treatments, impaired hearing, impaired decision making, wandering, and inappropriate behaviors. On 02/15/24 at 10:09 AM Administrative Licensed Nurse B reviewed R4's EMR and paper NSA/HCSP and acknowledged it did not identify services to be provided and who would provide services based on the findings of the FCS. The executive director failed to ensure designated staff completed R4's NSA/HCSP to include a description of services the resident would receive and who would provide those services related to medical treatments, impaired hearing, impaired decision making, wandering and behaviors. - R5's "Electronic Medical Record" (EMR) revealed she moved into the facility on02/05/18 with diagnoses of hemiparesis and diabetes type II. R5's "Functional Capacity Screen" (FCS) identified she was unable to participate in all activities of daily living except she was independent with eating. She was unable to participate in management of medications or medical treatments, had impaired cognition and communication, at risk for falls/unsteadiness,	S3085		

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S3085	Continued From page 10 and had impaired decision-making ability. On 02/12/24 at 11:15 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) were one document. R5's NSA/HCSP failed to address Hospice staff provided bathing assistance, services related to mobility throughout the facility, did not identify services related to impaired cognition or communication, and did not identify services or who would provide them for impaired decision-making ability. R5's NSA/HCSP also failed to identify that she received a pureed diet. On 02/14/23 at 01:28 PM Administrative Licensed Nurse B reviewed R5's EMR and paper chart and confirmed that it did not address that Hospice staff provided all of R5's bathing, did not address dressing needs, impaired cognition or communication services and did not include that she received a pureed diet. Administrative Licensed Nurse B acknowledged the NSA/HCSP did not address R5's needed based on her FCS. The executive director failed to ensure designated staff completed R5's NSA/HCSP to include a description of services the resident would receive and who would provide those services related to impaired cognition and communication, bathing, diet needs, and impaired decision-making ability.	S3085		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure	S3092		

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the review and, if necessary, revision of each negotiated service agreement 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;
(3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and
(4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-202 (d)(1)

The facility reported a census of 76 residents (R). The sample included three residents and six focused record reviews. Based on observation, interview, and record review the operator failed to ensure designated staff reviewed and revised the "Negotiated Service Agreement" for one (R5) of three sampled residents at least once every 365 days.

Findings included:

- R5's "Electronic Medical Record" (EMR) revealed she moved into the facility on -2/05/18 with diagnoses of hemiparesis and diabetes mellitus type II.

R5's EMR included a functional capacity screen completed on 07/06/23 which identified she was

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S3092	Continued From page 12 unable to participate in activities of daily living except she was independent with eating. She was also unable to participate in management of medications and medical treatments, had impaired cognition, at risk for falls and impaired decision-making ability. On 02/12/24 at 11:15 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) were one document. R5's EMR and paper chart included a NSA/HCSP completed on 06/15/22 and another one completed on 08/21/23, more than 365 days later. On 02/14/24 at 02:08 PM Administrative Licensed Nurse B reported each residents NSA?HCSP is to be completed whenever there is a significant change in status and at least annually. She reviewed R5's EMR and paper record and acknowledged the NSA/HCSP had not been completed annually. The executive director failed to ensure designated staff completed R5's NSA/HCSP at least annually.	S3092		
S3165 SS=F	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan.	S3165		

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S3165	Continued From page 13 This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (d) The facility reported a census of 76 resident (R)s. The sample included three residents and six focused record reviews. Based on interview for all residents and record review, the executive director failed to ensure all residents including three (R3, R4, R5) of three sampled residents "Negotiated Service Agreements" included the name of the licensed nurse responsible for the implementation and supervision of the "Health Care Service Plan". Findings included: - Review of R3's Electronic Medical Record (EMR) revealed he moved into the facility on 06/28/21 with diagnosis of dementia. R3's "Functional Capacity Screen" (FCS) dated 07/06/23 identified the resident required physical assistance with bathing, unable to manage his medications or medical treatments, had impaired cognition and impaired communication. He also had impaired vision and impaired decision-making ability. R3's "Negotiated Service Agreement" (NSA) dated 06/28/22 lacked the name of the licensed nurse (LN) responsible for the implementation and supervision of the resident's "Health Care Service Plan" (HCSP). - Review of R4's Electronic Medical Record (EMR) revealed he moved into the facility on	S3165		

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S3165	Continued From page 14 07/11/22 with diagnosis of Alzheimer's disease. Review of R4's "Functional Capacity Screen dated 07/06/22 identified he needed physical assistance with all activities of daily living, had impaired cognition, was at risk for falls, had wandering and inappropriate behaviors. Review of R4's "Negotiated Service Agreement" (NSA) dated 09/05/23 lacked the name of the licensed nurse responsible for the implementation and supervision of his "Health Care Service Plan" (HCSP). - Review of R5's Electronic Medical Record revealed she moved into the facility on 02/05/18 with diagnoses of diabetes mellitus type II and hemiparesis. R5's "Functional Capacity Screen" (FCS) dated 07/06/23 identified she was unable to participate in any activities of daily living except was independent with eating. She had bladder incontinence, impaired cognition and communication and was at risk for falls. R5's "Negotiated Service Agreement" (NSA) dated 06/15/22 lacked the name of the licensed nurse responsible for the implementation and supervision of R7's "Health Care Service Plan" (HCSP). On 02/14/24 at 02:14 PM Administrative Licensed Nurse B reported she had identified that none of the NSAs included the name of the licensed nurse responsible for the implementation and supervision of the health care service plan.	S3165		

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S3165	Continued From page 15 The executive director failed to ensure designated staff developed each resident's NSA to include the name of the LN responsible for the implementation and supervision of her health care service plan.	S3165		
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 76 residents. Based on observation and interview, the executive director failed to ensure all over-the-counter medications were labeled with the resident's full name. This includes the need for the resident's full name to be on the original manufacturer's medication package and the medication container/tube.	S3211		

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S3211	Continued From page 16 Findings included: - During initial tour of the facility the following concerns related to over-the-counter medications was identified: On 02/12/24 at 09:10 AM Certified Medication Aide (CMA) G unlocked 300-medication cart for inspection. Observation revealed the following over-the-counter medications without a resident's full name on the bottle: vitamin B12 and Vitamin D3. On 02/12/24 at 09:52 AM CMA E unlocked the 400-medication cart for inspection. Observation revealed the following over-the-counter medications without a resident's full name on the bottle: Vitamin B12, bottle of iron tablets, and a bottle of melatonin. On 02/12/24 at 10:20 AM CMA H unlocked the first-floor medication cart for inspection. Observation revealed the following over-the-counter medications without a resident's full name on the bottle: vitamin C3, bottle for "bone Health", multiple vitamin, melatonin, and a bottle of CBD oil. On 02/12/24 at 10:40 AM CMA I unlocked the second-floor medication cart for inspection. Observation revealed the following over-the-counter medications without a resident's full name on the bottle: magnesium, biotin keratin, centrum men's multivitamin, vitamin C, centrum woman's multivitamin, and a box of viactive.	S3211		

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S3211	Continued From page 17 On 02/12/24 at 09:27 AM Administrative Licensed Nurse B reported all over-the-counter medications needed to include the full name of the resident on the medications container. The executive director failed to ensure all over-the-counter medications included the full name of the resident they belonged to and included their name on the original manufacturer's medication package and the medication container.	S3211		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed 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	S3215		

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S3215	Continued From page 18 and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)(1)(4) The facility reported a census of 76 residents. Based on observation and interview, the executive director failed to ensure staff stored medications in secured/locked medication room, cabinet or medication cart where only licensed nurses and medications had access to stored medications. Saff also failed to store medications according to manufacturer's recommendations related to medication that needed to be kept refrigerated, and failed to ensure staff dated insulin pens to ensure the medication was not used beyond the manufacturer's recommended date of expiration. Findings included: - Observation on 02/12/14 at 11:28 AM Surveyor went into R4's room to interview resident. When surveyor went in to check the temperature of the hot water in R4's restroom observation revealed a bottle of nystatin powder, nasal spray, Tolnaftate (antifungal) powder on a shelf above the toilet.	S3215		

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S3215	Continued From page 19 On 02/12/24 at 11:36 AM Certified Medication Aide G reported residents in the memory care units are not to have any type of medication in their rooms. On 02/12/24 at 11:46 AM Administrative Licensed Nurse B stated the antifungal powders and ointments should have been kept in the medication cart and not in R4's restroom. The executive director failed to ensure all medications and biologicals were stored in a locked medication cabinet or cart so that only licensed nurses and certified medication aides had access to them. - During initial tour on 02/12/24 surveyor inspected medication carts to ensure proper medication storage. The following concerns were identified: On 02/12/24 at 09:52 AM, CMA E unlocked the 400-medication cart for inspection. Observation revealed a bottle of Lorazepam oral solution that was stored in the medication cart lock box. On 02/12/24 at 09:53 AM CMA E confirmed the box that contained the bottle of Lorazepam directed staff to store the medication in the refrigerator. Review of the manufacturer directions and label on the box the Lorazepam oral solution is to be stored in the refrigerator. The executive director failed to ensure designated staff stored Lorazepam oral solution	S3215		

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S3215	Continued From page 20 according to the manufacturers recommendations. - On 02/12/24 at 10:20 AM CMA H unlocked the first-floor medication cart for inspection. Observation revealed two insulin pens, Humalog, and Lantus and neither pen had a start date of use. On 02/12/24 at 10:40 AM CMA I unlocked the second-floor medication cart for inspection. Observation revealed a Lantus insulin pen that had been used without a start date of use. Review of the Humalog insulin pen manufacturer's recommendations revealed that open Humalog pen must be thrown away 28 days after first use, even if it still contained insulin. Review of the Lantus insulin pen manufacturers recommendations reveal that open Lantus pen must be thrown away 28 days after firs use, even if it still contained insulin. On 02/12/24 at 10:22 AM Administrative Licensed Nurse B acknowledged insulin pens needed to have the date on them when staff first put the pen in use. The executive director failed to ensure designated staff wrote the date an insulin pen was first put in use to ensure it was not used past the manufacturers recommended date of expiration.	S3215		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records	S3248		

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S3248	Continued From page 21 (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(1) The facility reported a census of 76 residents. Based on record review of five newly hired employees, the operator failed to have evidence of registration, and certification of training for three of four newly hired staff who required specialized education and training verified upon	S3248		

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S3248	Continued From page 22 hire. The findings included: - On 02/12/24 at 02:12 PM, review of four newly hired certified staff records who required specialized education and training verification revealed the following: Licensed Nurse C, hired on 01/16/23 did not have her licensure check completed until 02/28/23. Certified Medication Aide (CMA) D, hired on 01/26/23 had her CMA certification/registration checked on 02/12/24. CMA E, hired on 06/22/23 had her CMA certification/registration checked on 07/07/23. On 02/12/24 at 02:22 PM Executive Director A reported they could not find CMA D's original registry check so he printed it today and as far as the other two, he did not know why they would not have been verified upon hire. The Executive Director failed to ensure designated staff conducted registry check for verification of certification for certified and licensed staff prior to working at the facility.	S3248		
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	S3261		

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S3261	Continued From page 23	S3261		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-105(f)(11)

The facility reported a census of 76 residents (R). The sample included three residents and six focused record reviews. Based on interview and record review the operator failed to ensure three (R3, R4, and R5) of three sampled residents records contained documentation of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken.

Findings included:

- R3 moved into the facility on 06/28/21 with diagnosis of dementia.

R3's "Functional Capacity Screen dated 07/06/23 revealed he needed physical assistance bathing, could not manage his medications or medical treatments, had impaired cognition and communication. He also had impaired vision and impaired decision-making ability.

On 02/12/24 at 11:15 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) were one document.

R3's NSA/HCSP signed on 06/28/22 revealed the resident required stand-by-assistance for transferring in and out of the shower, required

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staff to administer his medications and that he had moderate dementia with significant short and possibly long-term memory deficit.

Review of R3's electronic progress notes included the following documentation:
12/28/2022 Pt experiencing increased nasal congestion and sneezing.
12/28/2022 VORB per Dr.(name) for Mucinex 600 mg ER 1-2 tabs PO q12h PRN NTE/4 tabs in 24hrs.Tylenol 500 mg 1-2 tab PO q6h PRN NTE 6 tabs/24hrs.

The record lacked follow up on the effectiveness of the Mucinex related to R3's nasal congestion and sneezing.

09/12/2023 - Nurse called to assess R3 due to having choking episodes during medication administration. Nurse contacted family and they attempted to take to immediate care center but returned to facility as the immediate care center did not do x-rays and the resident had quit coughing up phlegm. Staff instructed to administer 1-2 pills at a time to decrease risk of choking.

The record lacked follow-up if the resident had any further choking episodes after administering fewer medications at one time.

10/13/23 - Resident had behaviors toward another resident. Daughter took resident out of facility for an appointment.
10/13/23 - daughter returned with order to have resident sleep in his bed at night.

The record lacked follow-up related to the

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resident's behaviors upon return to facility or if the resident was cooperative with the new order to have him sleep in bed.

11/21/2023 - Resident very vocal and demanding, yelling at staff and very difficult to redirect. Resident wanting to leave and go find his wife.
11/21/23 - (later in the morning) - Resident very loud and attempting to leave memory care multiple times. Daughter contacted and she will pick up resident in about an hour.

The record lacked follow-up as to the resident's behavior and/or any interventions for redirection.

12/03/23 - after breakfast resident and another male resident were in a disagreement and R3 attempted to throw coffee on other residents twice. R3 was taken to the other side of memory care and then for a walk outside. Resident remained upset and then family came in later and took resident for a walk.

The record lacked follow-up as to the residents' behavior upon return to the memory care unit.

On 02/15/24 at 10:10 AM Administrative Licensed Nurse B reported she would expect staff to document when medications were changed, any change in condition or any need changed and would expect follow up on concerns that had been documented. Administrative Staff B acknowledged staff should have documented follow-up when the resident would have behaviors.

The executive director failed to ensure

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designated staff documented all symptoms of illness, incidents, what action was taken and effectiveness of that action.

- R4 moved into the facility on 07/11/22 with diagnosis of Alzheimer's disease.

R4's "Functional Capacity Screen dated 07/06/22 revealed he needed physical assistance with all activities of daily living, had impaired cognition, had a risk for falls, had impaired vision, hearing and impaired decision-making and also wandered and had inappropriate behaviors.

On 02/12/24 at 11:15 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) were one document.

R4's paper record included a NSA/HCSP dated 09/05/23 that identified the resident needed assistance with transfer in and out oaf the shower, reminders to use the toilet, reminders to use his walker or wheelchair for mobility and reminders for meal times and to eat his food. He also required staff assistance to administer his medications and he demonstrated inappropriate sexual behaviors and staff needed to manage his behaviors.

Review of R4's electronic progress notes revealed the following documentation:
10/06/2022 - the resident had increased edema to bilateral lower extremities and hands and had some difficulty with ambulating. Medical provider orders received for Lasix (diuretic) and for potassium (supplement).

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S3261	Continued From page 27 The record lacked follow up as to the effectiveness of the Lasix. 10/21/2022 -multiple episodes of loose stools the past few days. prn Imodium given. Medical provider notified and order to discontinue Lasix and hold Colace. The record lacked follow-up on the resident's loose stools. 11/14/2022 -Medical provider at facility and assess resident related to lower extremity and hand edema. New order for Bumex (diuretic) and potassium. The record lacked follow up as to effectiveness of medications as related to edema. 11/23/2022 - Resident complained of right upper quadrant (rib) pain and spouse suggested Coca-Cola. The record lacked follow up as to the resident's rib pain. 12/23/2022 -received medical provider order to discontinue Desitin cream due to area healed. The record lacked prior documentation of resident having a skin problem that required a medicated ointment treatment. 05/16/2023 - received order from medical provider for 1). Quetiapine (antipsychotic) 25 mg PO at noon and 100 mg at 9pm for behaviors/agitation. 2). Ativan (antianxiety) 0.5mg PO q4h PRN for anxiety.	S3261		

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The record lacked documentation of the resident having behaviors related to psychosis and or anxiety that would require an antipsychotic or antianxiety medication.

On 02/15/24 at 10:10 AM Administrative Licensed Nurse B reported she would expect staff to document when medications were changed, any change in condition or when any need changed and would expect follow up on concerns that had been documented. Administrative Staff B acknowledged staff should have documented behaviors to substantiate need for antipsychotic medications and the staff needed to follow up on Lasix and Bumex for edema.

The executive director failed to ensure designated staff documented all symptoms of illness, incidents, what action was taken and effectiveness of that action.

- R5 moved into the facility on 02/05/18 with diagnoses of hemiparesis and diabetes mellitus type II.

R5's "Functional Capacity Screen dated 07/06/23 revealed she was unable to participate in activities of daily living except she could feed herself independently. She was unable to manage her medications or medical treatments, had a risk for falls and impaired cognition and decision-making ability.

On 02/12/24 at 11:15 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care

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(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
S3261	Continued From page 29 Service Plan" (NSA/HCSP) were one document. R5's NSA/HCSP identified she needed assist in and out of the shower, needed assistance getting clothing out of closet and tying her shoes and putting on her coat. She was incontinent and requires staff to check and change incontinent products every two hours. She also required a mechanical lift for transfers and had her foods cut up into small pieces. . Review of R5's electronic progress notes revealed the following documentation: 12/28/2022 - new order to downgrade diet to mechanical soft for difficulty swallowing. 01/09/2023 - Speech therapy consult ordered related to continued cough. The record lacked documentation of evaluation of how resident tolerated mechanical soft diet until 02/18/23 when speech therapy came in and thought a mechanical diet was sufficient with no evidence of aspiration identified. 01/25/24 - resident not at baseline and not able to hold cup, eyes red and difficulty to wake. Hospice assessed and new order to discontinue scheduled Norco (narcotic) pain medication. The record lacked documentation of the effectiveness of the change in pain medications. On 02/14/24 at 02:19 PM Administrative Licensed Nurse B reviewed documentation and acknowledged she would have expected staff to follow up on the changes in R5's diet and changes in her medications and pain.	S3261		

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	N087075	A. BUILDING: _____ B. WING _____	02/15/2024

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S3261	Continued From page 30 The executive director failed to ensure designated staff documented all symptoms of illness, incidents, what action was taken and effectiveness of that action.	S3261		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3)(4) The facility reported a census of 76 residents. Based on record review and interview for all residents and all facility employees, the executive director failed to ensure disaster and emergency preparedness by ensuring performance of quarterly reviews of the facility's	S3280		

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S3280	Continued From page 31 emergency management plan with all employees and all residents and the completion of an annual emergency evacuation drill. Findings included: - On 02/14/23 Executive director provided information he stated was for the review of the emergency management plan with residents and staff. Review of the paperwork provided did not include the completion of an annual evacuation drill for 2022 or 2023. On 02/14/23 at 04:00 PM Executive Director A stated the annual evacuation drill for 2023 did not get completed. The executive director failed to ensure the facility completed an annual emergency evacuation drill. - On 02/14/23 Executive Director provided information he stated was for the review of the emergency management plan with residents and staff. Review of the paperwork provided included a review of the emergency management plan for employees conducted on 06/26-27/23 and a review conducted on 06/29/23 for residents. On 02/14/23 Executive Director A acknowledged the facility had not conducted quarterly reviews of the facility's emergency management plan. The executive director failed to ensure designated staff reviewed the facility's	S3280		

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S3280	Continued From page 32 emergency management plan with all residents and all staff quarterly.	S3280		
S3298 SS=E	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility reported a census of 76 residents. Based on observation, interview, and record review the operator failed to ensure dietary staff monitored food temperatures to ensure it was prepared and served at the proper temperature. Findings included:	S3298		

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S3298	Continued From page 33 - During initial tour on 02/12/24 at 11:47 AM in the main kitchen food service had already begun. Observation revealed there was a salad bar that residents could use that included cottage cheese, chopped up hard boiled eggs and cut up chicken. On 02/12/24 at 12:44 PM dietary staff J took the temperature of the following foods on the salad bar cart: cottage cheese read 42.8 degrees Fahrenheit (F), chopped hard boiled eggs read 42.9 F and the pieces of cut up chicken read a temperature of 44.2 F. On 02/12/24 at 03:00 PM Dietary Manager K reported the salad bar was accessible for residents throughout the day and the temperatures were supposed to be 41 or lower. He acknowledged the food temperatures were above 41 degrees and needed to be colder. - During initial tour on 02/12/24 at 09:50 AM Certified Medication Aide (CMA) D reported the kitchen staff take the temperature of the foods in the kitchen and they do not get any temperatures of food on the memory care units. CMA D reported the kitchen staff fix the residents' plates and then bring them down in a "hot cart" and they are then handed out to the residents after we get them all to the table. On 02/14/24 at 11:27 AM Dietary Manager K stated he had already prepared and called for the memory care staff to come and get the "hot carts" for the residents. On 02/14/24 at 11:33 AM Dietary Manager K temped the foods that had been brought down in	S3298		

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S3298	Continued From page 34	S3298		

the hot cart with the following results:
Pureed plate had temperatures of 108.3 F for the meat, 118.9 R for the sweet potatoes and 102.0 F for the green beans. He then checked the other pureed plate and the meat temperature read 113.3 F, the sweet potatoes read 119.2 F and the green beans read 109.8. He then checked a plate of regular consistency food and the meat read 120.6 F, the sweet potatoes read 125.4 F and the green beans read 120.6 F. Dietary manager K checked the setting of the "hot cart" and it was set to 112 degrees.

On 02/14/24 at 11: 37 AM Dietary manager K checked the food temperatures in the other Memory Care (MC) and the meat read 117 F, sweet potatoes were 122 degrees and checked the temperature of a chicken sandwich which read 135 degrees. Dietary manager K checked the setting of the "Hot cart" and it was set to 135 degrees.

On 02/14/24 at 11:48 AM, Dietary manager K confirmed the foods delivered to both memory care units did not keep foods hot that were to be served hot at the appropriate serving temperature.

Review of the "Focus on Food Safety" booklet from the Kansas Department of Agriculture dated August 2017 revealed the maximum cold holding temperature of 41 degrees F and the minimum hot holding temperature of 135 degrees.

Review of the "Food Storage" policy revised on 10/25/23 revealed potentially hazardous food, such as meat and milk products must be stored at 45 degrees F or below. Hot foods must be

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S3298	Continued From page 35 kept at 140 F or above during preparation and serving. The executive director failed to ensure foods maintained a proper serving temperature of 41 F or less for cold foods and 135 F or higher for hot foods.	S3298		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 76 residents (R). The sample included three residents and six focused resident reviews, and review of five newly hired employee records. Based on interview and record review the executive director failed to ensure the facility remained in	S3310		

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compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for two of five newly hired employees and for three (R3, R4, R5) of three sampled residents and for one (R10) of six focused resident reviews.

Findings included:

- Review of five newly hired employee files revealed the following:

Certified Medication Aide F, hired on 12/29/23 did not receive a second TB skin test.

Housekeeping staff G, hired on 01/09/24 had an initial skin test given on 01/09/24 but did not have it read and did not receive a second TB skin test.

On 02/12/24 at 02:24 PM Executive Director A reported new employees were to have TB symptoms screens done on hire and get a two-step TB skin test as well.

Review of the facility's "Screening for Tuberculosis" policy revised on 10/25/23 revealed each new employee shall have an initial TB symptom screen within seven days of employment and shall receive a two-step TB skin test within seven days of employment unless specific conditions are met.

The executive director failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes

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S3310	Continued From page 37 adopted by reference in KAR 26-39-105. - Review of R3's record revealed he moved into the facility on 06/28/21. R3's last TB symptom screen was completed on 01/13/22. - Review of R4's record revealed he moved into the facility on 07/11/22. R4's record lacked evidence the facility completed a TB symptom screen upon admission, or one completed annually after admission. - Review of R5's record revealed she moved into the facility on 02/05/18. R5's last TB symptoms screen was completed on 01/13/22. - Review of R10's record revealed he moved into the facility on 08/04/23. R10's record lacked completion of a TB symptom screen completed within seven days of moving into the facility. On 02/14/24 at 01:32 PM Licensed Nurse C reported TB symptom screens were to be completed upon admission and then again annually. On 02/15/24 at 01:25 PM, Administrative Licensed Nurse B had reviewed R3, R4, R5's records and confirmed each on had not had an annual TB symptoms screen completed. Administrative Licensed Nurse B also confirmed R10 did not have a TB symptom screen completed within seven days of moving into the facility. Review of the facility's "Screening for Tuberculosis" policy revised on 10/25/23 revealed each resident shall have a TB symptom	S3310		

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S3310	Continued From page 38 screen completed within seven days of admission and shall also be completed annually. The executive director failed to ensure designated staff completed a TB symptom screen annually for R3, R4 and R5 and failed to complete a TB symptom screen for R10 within seven days of admission.	S3310		