Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B030008	A. BUILDING: _____ B. WING _____	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART TO HEART HOME PLUS	3600 COLORADO ROAD POMONA, KS 66076

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named home plus facility conducted on 1/19/22 and 1/20/22.	S 000		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (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 home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' 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 26-42-104 (d)(3)(4) The facility reported a census of 3 residents. Based on record review and interview the Operator/Licensed Nurse failed to ensure disaster and emergency preparedness by the failure to conduct quarterly reviews of the home's emergency management plan with employees and residents. The Operator/Licensed Nurse also failed to conduct an emergency drill at least annually with staff and residents that included evacuation of the residents to a secure location.	S5215		

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

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S5215	Continued From page 1 This failure had the potential to effect all residents who lived in the facility. Findings included: - On 1/19/22 at 11:09 AM Operator/Licensed Nurse A stated they did the fire drills every other month, go over things when the weather is bad, and asked Resident (R) 112 what she would do if there was a fire or a tornado. Operator/Licensed Nurse stated she had nothing in writing to show that she had reviewed the emergency management plan with residents or with their one employee. The Operator/Licensed Nurse failed to review the emergency management plan with residents and employees quarterly. - On 1/19/22 at 11:10 AM Operator/Licensed Nurse A reported they do the fire drills and the only written information she had was on the report. Review of the report identified by Operator/Licensed Nurse A revealed on 1/7/22 the fire drill done and it took 1 minute for R112 to exit the facility. It failed to identify a start and stop time for the drill, how many residents and how many staff participated in the drill or where the resident's evacuated to. The operator/Licensed Nurse A failed to ensure disaster and emergency preparedness by the failure to conduct annual emergency evacuation drills.	S5215		

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S5301	Continued From page 2	S5301		
S5301 SS=E	26-42-205 (d) (3) Facility Administration of Medications (d) (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d)((3)(D) The facility reported a census of 3 residents. The sample included 3 residents. Based on record review and interview the Operator/Licensed Nurse failed to ensure the documentation of the administration of medications immediately before or after completion of the task and failed to include the actual clock time the medication was administered for 2 (R113 and R114) of 3 sampled Residents (R). Findings included:	S5301		

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S5301	Continued From page 3 - Review of Resident (R) 113's medical record revealed she moved into the facility on 10/1/2002 with diagnoses of Multiple Sclerosis, osteoporosis, and kidney stones. The resident's Functional Capacity Screen dated 12/4/21 revealed the resident required physical assistance with medication management. The residents Negotiated Service Agreement/Health Care Service Plan dated 12/4/21 revealed caregivers would prepare and administer medications. Review of the resident's physicians orders included orders for Senna S 8.5/50 mg as needed at hour of sleep (HS) for constipation and for Miralax 1 teaspoon as needed in the AM for constipation. Review of the December 2021 Medication administration record revealed the resident received Senna/Docusate 8.6/50 mg on 12/8,9,10,11,12,20 & 21/2021. The resident also received Miralax on 12/13,14,15,16,23/2021. The Record failed to identify a clock time that the medication was administered. On 1/20/22 at 10:15 AM Operator/Licensed Nurse A reported that it said HS for hour of sleep on the Senna and the Miralax said PM in AM. Operator Licensed Nurse A reported she did not realize it needed to have the actual clock time that it was given. The Operator/Licensed Nurse failed to ensure the residents medication record included the actual clock time that medications were administered.	S5301		

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- Review of R114's medical record revealed he moved into the facility on 1-11-16 with diagnoses of insulin dependent diabetes mellitus, coronary artery disease and chronic kidney disease.

Review of the residents Functional Capacity Screen dated 1/6/21 revealed the resident was unable to manage his medications or medical treatments.

Review of the residents Negotiated Service Agreement/ Health Care Service Plan dated 1/6/21 revealed the caregiver prepared and administered the residents medications.

Review of the resident's physician orders included an order for Clonidine 0.1mg daily and 1 as needed (PRN) for Systolic Blood Pressure (SBP) greater then 150. It also included a Sliding Scale Insulin (SSI) order for Novolog Insulin with meals - 100-149 give 6 units, 150-199 give 8 units, 200 - 249 give 10 units, 250 - 299 give 12 units, 300-349 give 14 units, 350-399 give 16 units, 400-449 give 18 units, 450 - 499 give 20 units and 500 or greater give 22 units.

Review of the December 2021 Medication Administration Record (MAR) revealed the resident's SBP was greater than 150 on the 14th, 15th, 16th, 19th, 24th, and 27th with no documentation that staff administered the PRN dose of Clonidine as ordered. It also failed to have the actual clock time for the days that staff did administer the PRN medication. The MAR also include sliding scale insulin administration which included "AM, MID, PM" for administration times instead of the actual clock time it was administered.

Review of the January 2022 MAR revealed the

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S5301	Continued From page 5 residents SBP was greater than 150 on the 8th and 18th without documentation that staff administered the PRN dose as ordered and failed to include the actual clock time when it was administered. The January 2022 MAR also failed to include the actual clock time of administration for the resident's insulin or his eye drops. On 1/20/22 at 10:32 AM Operator/Licensed Nurse A reported that she knows she would have given him the extra dose as ordered and must have forgotten to initial that she gave it. She also stated she did not realize it needed to say the actual time given since she gave it with his other morning medications. The Operator/Licensed Nurse failed to ensure staff documented the administration of medications immediately before or after completion of the task and failed to include the actual clock time the medication was administered for R113 and R114.	S5301		
S5315 SS=D	26-42-205 (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 home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked	S5315		

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medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals.
(2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides.
(3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home.
(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 26-42-205(h)

The facility reported a census of 3 residents. Based on observation, interview, and record review the Operator/Licensed Nurse failed to ensure staff stored insulin securely and according to federal and state laws and regulations.

Findings included:

- Review of the resident roster provided by Operator/Licensed Nurse A revealed 1 resident received insulin injections.

During initial tour on 1/19/22 at 11:53 AM observation of an unlocked cabinet by the kitchen

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S5315	Continued From page 7 table was a Levemir flex touch pen and a NovoLog flex pen. Neither pen had a resident's name on it or the date the pen was initially used. The cabinet also included a bottle of Occuvite eye vitamins in the cabinet without no name on them. On 1/19/22 at 11:42 AM Operator/Licensed Nurse A, stated R114 is the only resident who takes the insulin. She confirmed it was not stored in a locked cabinet like it is supposed to be. The Operator/Licensed Nurse A failed to ensure insulin was stored securely and properly in accordance with federal and state laws and regulations.	S5315		