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	N089002	A. BUILDING: _____ B. WING _____	10/27/2021

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OAK CREEK SENIOR LIVING	3224 SW 29TH STREET TOPEKA, KS 66614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaints #140801, #141374, and #141461 conducted at the above named facility conducted on 10/25,26.27/2021.	S 000		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (i) The facility reported a census of 31 residents. The sample included 3 residents and 3 focused record reviews. Based on observation, interviews and record review the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of 1(#102) of 3 sampled residents who developed a pressure ulcer. Findings included: - On 10-25-21 at 2:05 PM surveyor reviewed the resident roster with licensed nurse B who confirmed only one resident, #102 had any type of skin condition and described it as an open area on her coccyx. Review of resident #102's medical record revealed the resident moved into the facility on 2-6-2014 with diagnosis of diabetes mellitus type	S3171		

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

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S3171	Continued From page 1	S3171		

2, congestive heart failure, depression and reflux disease.

Review of the resident's functional capacity screen dated 2-4-21 revealed the resident required physical assistance with bathing, and supervision with dressing, toileting, and transfers. It also identified the resident had bladder incontinence.

Review of the resident's negotiated service agreement/health care service plan (NSA/HCSP) identified the resident's family gave the resident her scheduled baths and if unable staff would do it. Staff helped the resident with choosing her clothing and provided cues and reminders for toileting needs. It identified the resident knew if she had been incontinent but needed staff assistance to change incontinent products as needed. It also identified the resident was unable to manage her medications or her medical treatments which facility staff would do for her.

Review of the resident's nurses note's included an entry dated 10-22-21 that the resident was seen on 10-21-21 by medical provider for a skin condition, new orders received. The record lacked any information regarding assessing the skin wound, any type of treatment plan to promote healing of the skin condition.

Review of the medical providers progress note dated 10-21-21 revealed the resident complained of pain in her bottom. Nursing staff explained the resident had a stage 2 pressure ulcer. Plan: to bring in skilled nursing to address stage 2 ulcer; OT to evaluate for change of position, transfers and possibility of pressure relieving cushion for her to use in recliner and on power chair; and to encourage and assist as needed to offload

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S3171	Continued From page 2	S3171		

pressure while seated in recliner.

Review of the residents medication administration record and treatment record for September 2021 and October 2021 included an order for Zinc Oxide 20% ointment : apply twice a day as needed to buttocks for protection. The record indicated the treatment had not been administered in September or in October as a preventative or after staff identified the resident had an open ulcer.

During an interview on 10-26-21 at 1:38 PM certified medication aide E confirmed the resident had a small open area a little lower than her coccyx. She also confirmed that the residents family did all of her showers so her family may have been the one who found it. Staff E did not know how long the resident had the sore.

Observation on 10-26-21 at 1:51 PM revealed as the resident stood to get out of her recliner she scooted her butt to the front of the chair and then stood with assistance of licensed nurse B. The resident pulled down her pullup, which was dry, and showed the nurse and surveyor the sore was on the left side of her gluteal cleft. The open area was approximately .3 centimeters in diameter and the surrounding skin was red, dry and chafing. Observation also revealed no pressure reducing cushion in the residents recliner or in her electric wheelchair.

Interview on 10-26-21 at 2:06 PM license nurse B stated she was out of the office when it was found and though it was found sometime between 10-18-21 and 10-21-21. License nurse B reported operator A informed her of the open area and also confirmed she should have started the Zinc Oxide treatment and tried to do something to

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S3171	Continued From page 3 relieve the pressure. The operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of 1(#102) of 3 sampled residents who developed a pressure ulcer.	S3171		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 24-41-205(d)(1) The facility reported a census of 31 residents. The sample included 3 residents and 3 focused record reviews. Based on interview and record review the operator failed to ensure 1 (#102) of 2	S3200		

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S3200	Continued From page 4	S3200		

residents who received insulin received it according to physicians orders. The operator also failed to ensure certified medication aide C, who administered medication out of the south card had a current medication aide certificate.

Findings included:

- On 10-25-21 at 2:05 PM Operator A provided the newly hired employees information as requested and upon handing the surveyor the information stated; One of the med aides certification had expired. Operator A stated the med aide is not passing medications the rest of the day but can work the floor as her nurse aide is current.

Review of certified medication aide C's employee file revealed her medication certificate expired on 10-18-2021.

Observations - during tour when surveyor checked medication carts certified medication aide C unlocked the medication cart and proceeded to do narcotic count with surveyor and checking of the medication drawers.

On 10-26-21 at 1:25 PM review of the south cart medication administration record book for whom the facility staff were responsible for administration revealed certified medication aide C administered medications to the residents on 10-21-21, 10-22-21, and for the morning and noon medication passes on 10-25-21.

During an interview on 10-26-21 at 3:32 PM Operator A confirmed the medication aides certificate had expired and from the 18th on she should not have passed medications.

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S3200	Continued From page 5 The operator failed to ensure only a licensed nurse or certified medication aide passed medications for which the facility had responsibility. - Review of resident #102's medical record revealed the resident moved into the facility on 2-6-2014 with diagnosis of diabetes mellitus type 2. Review of the resident's functional capacity screen dated 2-4-21 revealed the resident could not manage her own medications. Review of the resident's negotiated service agreement/health care service plan identified the facility staff would manage and administer the residents medications. It identified the resident would have blood sugar checks completed as ordered and the certified medication aides would dial the resident's insulin pen and the resident would self-inject the insulin. Review of the resident's medication administration record (MAR) for October 2021 revealed the facility staff held the residents morning Lantus insulin on 10-1,2,5,9-21 due to the resident's blood sugar read below 100. Staff also held the resident's bedtime dose of Lantus insulin on 10-5,6,7-21 for the same reason. Surveyor reviewed the residents medical record and current MAR and could not find a physicians order to hold the resident's insulin if the resident's blood sugar was below 100. On 10-26-21 at 1:09 PM certified medication aide E reported every resident who took insulin had a standing order to hold their insulin if the blood	S3200		

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S3200	Continued From page 6 sugar read below 100 and to call the nurse if it was over 400. If the resident's blood sugar is below 100 we then give the resident a snack. On 10-26-21 at 1:38 PM certified medication aide D reported staff gave the resident her medications and if her blood sugar was below 100 we are to hold the insulin and document on the record what the residents blood sugar read and we let the nurse know we held it. If it is below 100 we will give the resident milk and a sandwich. 10-26-21 at 1:45 PM certified medication aide E looked at the residents MAR and treatment record (TAR) to see where it said to hold the resident's insulin and she could not find it. Staff E stated the bottom of the log said to notify the LPN if it was less than 70 or above 399. Staff E confirmed the residents MAR and TAR did not include an order to hold the resident's insulin if the blood sugar was below 100. On 10-26-21 at 3:04 PM licensed nurse B reported she thought there was a standing order to hold the resident's insulin if the blood sugar was below 100. Licensed nurse B looked in the resident's record and confirmed the resident did not have an order for holding the insulin if her blood sugar was below 100. The operator failed to ensure staff administered resident #102's medications according to physicians orders.	S3200		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and	S3215		

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S3215	Continued From page 7 biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (h) (4) The facility reported a census of 31 residents. Based on observation and interview the operator failed to ensure licensed nurses and certified	S3215		

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S3215	Continued From page 8	S3215		

medication aides could not administer medications beyond the medication manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated insulin pens once opened for 4 (#101, #107, #108, #109) of 11 residents whose insulin the facility managed.

Findings included:

- Review of the resident roster provided by operator A on 10-25-21 revealed the facility had 11 residents whom the facility was responsible for dialing the residents insulin pen and then the resident self injected the insulin.

Observation on 10-25-21 at 12:53 PM certified medication aide C opened the medication cart for the south hall and revealed in the drawer were multiple containers with insulin supplies. Resident #107 had a partially used Levemir FlexTouch and Novolog Flex pen that did not have the date when staff began using either pen. Certified medication aide E then opened the north medication cart which revealed resident #101 had a partially used Basaglar and a Novolog Flex pen without a date on it that staff began using either pen. Resident #108 had a Novolog Flex pen without the date staff started using it and resident #109 had a Novolog Flex pen that staff also failed to put the date on that they started to use the pen.

Interview on 10-25-21 at 12:54 PM certified medication aide C reported that all of the insulin pens were supposed to have tape on them with the resident's name and the date staff opened the pen.

On 10-25-21 at 12:55 PM operator A confirmed that all insulin pens were to have tape or sticker

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S3215	Continued From page 9 on them to identify the date staff started using the pen. At 12:56 PM certified medication aide E reported the medication aide who get a new pen out of the refrigerator are to put the date on it when it was opened. Staff E stated there would be no way to tell for sure when the insulin in the pens that were not dated would expire. The Novolog Flex pen manufacture recommended to store opened insulin at room temperature for up to 28 days and discard even if insulin remained. The Levemir FlexTouch manufacture recommended to store opened insulin at room temperature for up to 42 days and discard even if insulin remained. The Basaglar Kwickpen manufacture recommended to store the opened insulin at room temperature for 28 days and discard even if insulin remained. The operator failed to ensure licensed nurses and certified medication aides could not administer medications beyond the medication manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated insulin pens once opened.	S3215		
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 10	S3261		

This REQUIREMENT is not met as evidenced by:
KAR 26-421105(f)(11)

The facility reported a census of 31 residents The sample included 3 residents and 3 focused record reviews. Based on interview and record review the operator failed to ensure the record contained documentation of all incidents, symptoms, and other indications of illness or injury, action taken, and results of the action for 2 (resident #101 and #102) of 3 sampled residents.

Findings included:

-- Review of resident #101's medical record revealed he moved into the facility on 2-4-20 with diagnoses of urinary retention, congestive heart failure, chronic kidney disease and coronary artery disease.

Review of the resident's functional capacity screen dated 2-2-21 revealed the resident was independent with activities of daily living except for bathing. It also identified the resident was unable to manage his medications and had a current or recent problem with fall risk.

Review of the resident's negotiated service agreement/health care service plan dated 2-2-21 revealed staff assisted the resident in preparing for a shower, managed his medications and medical treatments.

Review of the resident's nurses notes revealed the following documentation:

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S3261	Continued From page 11 On 2-8-21 at 1:37 AM licensed nurse B noted: - On 2-7-21 the resident fell on the patio...the resident said his right knee gave out on him and he complained of right leg pain prior to the fall and after the fall. The resident also had a skin tear to his right elbow...Resident provided a walker to temporarily use when the weather is bad...Staff assisted the resident up to a wheelchair. The record lacked any follow up as to the resident's leg pain, skin tear condition or if the resident had nay other problems develop status post fall. On 3-18-21 at 4:30 PM licensed nurse B noted the medical provider wrote a new order for a chest X-ray and that mobile X-ray was contacted. The record lacked information if/when the X-ray was done and the results of the X-ray. On 4-6-21 Operator A noted that on 4-5-21 the resident was in the wheelchair, complained of increased weakness. Operator A noted the resident appeared swollen all over and had a 3 pound weight gain since 3-30-21. Operator A notified medical provider and received an order for Torsemide 60 milligrams for 3 days. The record lacked further documentation if the resident developed any respiratory problems with the additional fluid, if the increased medication worked to decrease the resident's swelling or any other changes in the residents status. On 7-16-21 at 5:00 PM licensed nurse B noted she would be assisting the resident with a healthy diet to loose weight and that a daily food journal had been started. The residents record lacks further documentation regarding licensed nurse B meeting with the	S3261		

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resident to help with a healthy weight loss plan.

The residents record failed to include the actions taken and results of those actions after the resident had a fall, after the physician ordered a chest X-ray, after the resident had increased weight gain and increased diuretic medications, and also after the licensed nurse had developed a plan to help the resident lose weight in a health manner.

On 10-26-21 at 3:20 PM licensed nurse B confirmed the record did not include fall follow up or that the chest X-ray had been completed and what the results were. She also stated that she met with the resident every Tuesday to go over the weight loss plan and the resident is not very compliant with the plan.

The operator failed to ensure designated staff included documentation in the residents record as to the residents incident/illness/symptoms and the action taken and the results of those actions.

- Review of resident #102's medical record revealed the resident moved into the facility on 2-6-2014 with diagnosis of diabetes mellitus type 2.

Review of the resident's functional capacity screen dated 2-4-21 revealed the resident needed physical assistance with bathing and supervision with dressing, toileting, and transfers. It identified the resident could not manage her medications or medical treatments.

Review of the resident's negotiated service agreement/health care service plan identified the resident's family provided the resident's bathing

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assistance and staff provided cues and reminders related to other activities of daily living. It also identified the facility staff would manage and administer the residents medications. It identified the resident would have blood sugar checks completed as ordered and the certified medication aides would dial the resident's insulin pen and the resident would self-inject the insulin.

Review of the resident's nurses notes included the following documentation:
On 10-14-21 at 11:45 AM licensed nurse B documented the resident returned from the hospital at 4:30 PM on 10-13-21 with a Foley catheter and new orders.
The residents record lacked documentation as to any type of illness, symptom the resident had or when she left the facility and went to the hospital.

On 10-22-21 at 1:00 PM licensed nurse B noted that the resident was seen on 10-21-21 by the medical provider related to a "skin concern".
The record lacked information as to when staff identified the resident had a skin concern, assessment of the resident's skin and any actions taken related to the skin concern.

At 3:09 PM operator A reported the resident had called her family and they came and took her into the hospital. The day prior the resident had a large bowel movement. The operator confirmed she should have documented that the resident had left the facility with family and went to the hospital, and staff should have documented an assessment of the resident's open sore.

The operator failed to ensure designated staff included documentation of all incidents, symptoms and other indications of illness of injury including the date, time of occurrence,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK SENIOR LIVING	3224 SW 29TH STREET TOPEKA, KS 66614

(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 14 action taken, and results of the action.	S3261		