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	B001001	A. BUILDING: _____ B. WING _____	C 05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND MEADOWS, LLC	1727 OREGON ROAD IOLA, KS 66749

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with complaint numbers 162172, 160584, 158601, and 151425 for the above named facility conducted on 5/6/2021, 5/10/2021, 5/11/2021 and 5/12/2021.	S 000		
S5026 SS=D	26-42-101 (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 26-42-101 (f) (1) (B) The facility reported a census of 12 residents. Based on interview and record review the operator failed to ensure resident #349 was not neglected when she did not receive services for hygiene as defined in the resident signed negotiated service agreement under bathing. Findings included: - Record review for resident #349 revealed an admission date of 8/31/2016, with diagnoses of diabetes type 2, and dysphagia. The annual functional capacity screening dated	S5026		

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

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S5026	Continued From page 1 8/30/2020 revealed the resident had impaired short- and long-term memory, impaired memory recall and decision making. She required physical assistance with bathing, dressing and toileting, and managing her medications. She was a fall risk, had impaired hearing, and required a wheelchair for mobility. The annual negotiated service agreement dated 8/30/2020 identified facility staff to assist with bathing 2 times a week. The negotiated service agreement also identified the resident would require assistance with personal hygiene, morning and evening dressing, and fall prevention. The standard assessment with behavioral care items / health service plan instructed staff to" provide an extensive degree of assistance" with bathing, she would require two persons assist, and will need help washing hair, back, feet and her bottom then drying. Review of December 2020 bathing and cares sheet revealed the resident received a bath on the following days in December: 2nd, 8th, 11th, 20th, 23rd, and 31st. Interview with operator C on 5/11/2021 confirmed the check off sheet for bathing in December lacked entries 2 times a week for bathing and contained only 6 entries. The operator failed to ensure resident #349 was not neglected when she did not receive services for hygiene as defined in the resident signed negotiated service agreement under bathing.	S5026		

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S5192	Continued From page 2	S5192		
S5192 SS=E	26-42-206 (e) Food Preparation (e) 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 26-42-206 (e) The facility reported a census of 12 residents. Based on observation, interview and record review the operator failed to ensure staff prepared food using safe methods and serving food at the proper temperature. Findings included: - Record review on 5/6/2021 at 10:45 AM revealed the record lacked entries for the following days in 2021; January 1, 8, 9, 13, 18, and 25 February 8	S5192		

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S5192	Continued From page 3 March 7, 16, 17, 22, 23, 24, and 25 April 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 20 May 2, 3, 4, 5, and 6. Interview on 5/6/20201 with operator C confirmed the food temperature log lacked entries on the listed days. The operator failed to ensure staff prepared food using safe methods and serving food at the proper temperature.	S5192		
S5230 SS=E	26-42-207 (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; (c) Each administrator or operator shall ensure the home ' 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 26-42-207 (c)	S5230		

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S5230	Continued From page 4	S5230		

The facility reported a census of 12 residents. The sample include 3 residents and 5 newly hired personnel.
Based on interview and record review the operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-205 for 5 sampled staff (licensed nurse D, certified medication aides A and E, and certified nurse aides F and G).

Findings included:

- Review of licensed nurse D personnel record revealed she began employment on 4/12/2021. The employee record lacked the evidence of the 2-step tuberculin test within 7 days of employment.

Review of certified medication aide A personnel record revealed she began employment on 9/22/2020. The employee record lacked the evidence of the 2-step tuberculin test within 7 days of employment.

Review of certified medication aide E personnel record revealed she began employment on 8/18/2020. The employee record lacked the evidence of the 2-step tuberculin test within 7 days of employment.

Review of certified nurse aide F personnel record revealed she began employment on 6/12/2020. The employee record revealed she received the 1st step of the 2-step tuberculin test on 8/27/2019. The record lacked evidence of the 2nd step being performed.

Review of certified nurse aide G personnel record revealed she began employment on

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S5230	Continued From page 5 3/12/2021.The employee record lacked the evidence of the 2-step tuberculin test within 7 days of employment. The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-205 for 5 sampled staff (licensed nurse D, certified medication aides A and E, and certified nurse aides F and G).	S5230		
S5265 SS=D	26-42-205 (a) (1) Medication Self Administration Assessment (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (a)	S5265		

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S5265	Continued From page 6 The facility reported a census of 12 residents. The sample included 3 residents. Based on interview and record review the operator failed to ensure a licensed nurse perform an assessment on resident #349 to determine if the resident could perform the function safely and accurately without staff assistance. Findings included: - Record review for resident #349 revealed an admission date of 8/31/2016, with diagnoses of diabetes type 2, and dysphagia. The annual functional capacity screening dated 8/30/2020 revealed the resident had impaired short- and long-term memory, impaired memory recall and decision making. She required physical assistance with bathing, dressing and toileting, and managing her medications. She was a fall risk, had impaired hearing, and required a wheelchair for mobility. The annual negotiated service agreement dated 8/30/2020 identified facility staff to assist with bathing 2 times a week, toileting, personal hygiene, and facility would hand the resident the dialed insulin pen and the resident would self-inject. The standard assessment with behavioral care items / health service plan instructed staff to assist resident in taking all routine and as needed medications according to physician's orders. The record lacked an assessment for self-administration of medication. Interview with operator C on 5/12/2021 confirmed the resident record lacked the self-administration	S5265		

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S5265	Continued From page 7 of medication assessment. The operator failed to ensure a licensed nurse perform an assessment on resident #349 to determine if the resident could perform the function safely and accurately without staff assistance.	S5265		
S5316 SS=D	26-42-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist.	S5316		

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S5316	Continued From page 8 This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (i) The facility reported a census of 12 residents. Based on observation, interview and record review the operator failed to ensure a licensed nurse maintained the reconciliation record and accurate disposition of the Hydrocodone/aspirin 7.5/325 milligrams tablets, a controlled medication for resident #271. Findings included: - Review of resident #271 record revealed an admission date of 4/13/2021. The functional capacity screen dated 4/12/2021 recorded resident required physical assistance with medication management. The negotiated service agreement dated 4/12/2021 identified the resident would receive staff assistance with medication management. Record review of the delivered Hydrocodone/aspirin 7.5/325 milligram from the pharmacy revealed deliveries on the following dates; February 17, 2021 quantity of 90 tablets of Hydrocodone/aspirin 7.5/325 milligram March 9, 2021 quantity of 90 tablets of Hydrocodone/aspirin 7.5/325 milligram March 31, 2021 quantity of 90 tablets of Hydrocodone/aspirin 7.5/325 milligram Review of resident #271 orders revealed the	S5316		

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S5316	Continued From page 9	S5316		

following:

A signed physician order for Hydrocodone/aspirin 7.5/325 milligrams starting on 12/29/2020.

A signed physician order for Hydrocodone/aspirin 10/325 milligrams on 4/9/2021 and to discontinue the Hydrocodone/aspirin 7.5/325 milligrams.

Review of the electronic resident medication administration record revealed the facility administered 171 tablets of Hydrocodone/aspirin 7.5/325 milligrams between the dates of 2/17/2021 and 4/9/2021.

The as needed medication administration record revealed the following;

February 2021 - 72 Hydrocodone/aspirin 7.5/325 milligram tablets were administered.

March 2021 - 78 Hydrocodone/aspirin 7.5/325 milligram tablets were administered.

April 2021 - 20 Hydrocodone/aspirin 7.5/325 milligram tablets were administered.

Record review of the narcotic count sheet and administration records revealed the following; the facility narcotic count book lacked the count sheets for resident #271 Hydrocodone/aspirin 7.5/325 milligrams for the month of March. The record contained the entries for 1/23/2021 thru 2/21/2021 for the Hydrocodone/aspirin 7.5/325 milligrams.

Interview with pharmacist H, confirmed there were 100 Hydrocodone/aspirin 7.5/325 milligrams tablets not administered.

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S5316	Continued From page 10 Interview on 5/11/2021 at 2:30 PM with operator C confirmed the facility narcotic count and administration book lacked the records for the administration of the March doses of the Hydrocodone/aspirin 7.5/325 milligrams, and the cards containing the tablets were unable to be found. Interview on 5/11/2021 at 4:12 PM operator C confirmed she found 1 full card of 30 tablets and 1 card with 12 tablets. She stated she found them under a drawer in her desk, and she had staff witnesses when cards were discovered. She confirmed she did not know where the rest of the 100 un administered tablets were at. The operator failed to ensure a licensed nurse maintained the reconciliation record and accurate disposition of the Hydrocodone/aspirin 7.5/325 milligrams tablets, a controlled medication for resident #271.	S5316		