STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	R 08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL WICHITA, KS 67208

(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 the revisit for correction order 20-30 conducted on 08/24/2020 and 08/25/2020.	{S 000}		
{S5105} SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus 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 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 26-42-202 (a) (1)(2)(3) The facility reported a census of 4 residents. The sample included 3 residents and 1 focused review. Based on observation, interview and record review the operator failed to ensure the written negotiated service agreement for each resident was based on the functional capacity screening and the service needs for 3 of 4 sampled residents (#1189, #1214, and #1267) included a description of services the resident would receive, provider of each service and the	{S5105}		

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

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{S5105}	Continued From page 1	{S5105}		

party responsible for payment if outside resources provide a service.

Findings included:

- Record review on 08/25/2020 at 8:30 AM for resident #1214 revealed an admission date of 02/10/2020 with diagnoses of dementia, depression, anxiety, diabetes mellitus and hypertension.

The admission functional capacity screen (FCS) dated 02/10/2020 identified the resident with cognitive impairment in short-term and long-term memory, memory recall and decision making. She needed physical assistance with all activities of daily living (ADLs) (bathing, dressing, toileting, transfers, walk/mobility). Under "Current or recent problems and risks" identified the resident with falls/unsteadiness, impaired vision, wandering behavior, socially inappropriate disruptive behavior and impaired decision making.

The negotiated service agreement (NSA) and without any addendums/amendments, dated 02/10/2020 listed services of medications by facility staff, behavioral management included the name of a physician-based company (medication management only). The NSA did not include what types of behaviors the resident needed managed as identified by the FCS (wandering and socially inappropriate behaviors). Under the section for Health and Wellness Monitoring licensed nurse/operator B marked falls, a physician-based company's name and facility staff but did not include any specifics needs of the resident or services the staff provided to reduce the risk of the resident falling.

Review of the August 2020 medication

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{S5105}	Continued From page 2	{S5105}		

administration record revealed the resident received the following medications for treatment of mood disorder, anxiety, depression or dementia:
Depakote DR 250 milligrams (mg) by mouth twice a day for mood disorder
Lorazepam 0.5 mg by mouth twice a day (no identified reason)
Remeron 30 mg by mouth at bedtime for depression
Pristiq ER (extended release) 50 mg by mouth daily for mood
Exelon 13.3 mg/24-hour patch for dementia

Review of the nursing notes between 03/06/2020 (no time) and 08/12/2020 at 4:00 PM revealed the resident had medications changes and her behaviors had decreased but still occurred with a note on 05/28/2020 at 2:25 PM resident had episode of verbal aggression to the other residents during lunch telling other residents how to eat. On 07/10/2020 at 10:35 AM resident still has behaviors off and on and primary care provider adjusted medications.

Observation on 08/24/2020 at 2:26 PM the resident propelled herself in the wheelchair from the living room into the dining room and back with no discernable purpose. At 3:00 PM she wandered about in her wheelchair from living room, thru the dining room and into the kitchen area. On 08/25/2020 at 11:35 AM revealed the resident began crying for no known reason and wandered propelling self in her wheelchair about the area from the living room to the dining room without a known purpose.

Interview on 08/25/2020 at 10:42 AM with licensed nurse/operator B confirmed he did not amended the NSA to include a description of the

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{S5105}	Continued From page 3	{S5105}		

services needed for behaviors with it only listing the name of a physician group and the NSA failed to include specific services the resident needed to reduce her risk of falls.

The operator failed to ensure the written negotiated service agreement for resident #1214 was based on the functional capacity screening and the service needs included a description of services the resident would receive (fall risk, behavioral management) and listed only a physician group with responsibility to manage.

- Record review on 08/25/2020 for resident #1267 revealed an admission date of 02/10/2020 with diagnoses of dementia, diabetes, hypertension and pain.

The admission functional capacity screen (FCS) dated 02/10/2020 identified the resident with cognition deficit in all aspects. The coding for activities of daily living were changed and written over at an unknown time after the 02/10/2020 and now indicated the resident needed physical assistance with transfers, walking and mobility. She was marked with falls/unsteadiness, impaired vision, hearing, decision making and wandering behavior. The FCS identified an outside provider for diabetic management.

The negotiated service agreement dated 02/11/2020 identified services of transfer assistance by 1 staff and resident walked without any assistive devices. Under the health care services section licensed nurse/operator B marked medications by facility staff, management of medical treatments by a physician's group (normally prescriber only), behavior management marked with wander in the house and no specifics to the safety of the resident related to

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{S5105}	Continued From page 4	{S5105}		

wandering. The NSA listed the name of an outside provider of services but not what services they provider or who was the responsible party for payment of those services. Under the section health and wellness monitoring licensed nurse/operator B marked the resident as wandering and "in the house" again with no specifics on what services would be provided to ensure the resident's safety related to wandering. The place for falls/unsteadiness was not marked at all.

Review of the nursing notes between 03/20/2020 at 4:00 PM through 07/10/2020 at 4:00 PM revealed an entry on 03/30/2020 at 11:00 AM the resident alert with dementia and wandering in the house, easy to redirect and non-verbal. She needs maximum assist with activities of daily living. The note listed an outside provider of services as responsible for management of diabetes.

On 08/24/2020 at 3:06 PM observation revealed the resident ambulated independently and wandered/meandered around in the dining room, kitchen door entrance and then in the living room picking up/fidgeting with pillows from the couch with no discernable purpose.

Interview on 08/25/2020 at 11:00 AM licensed nurse/operator B confirmed the resident could independently rise, walk about, had wandering behavior and was at risk for falls due to unsteadiness. He confirmed the NSA lacked a description of services to address the behaviors and fall risks and name of persons responsible for services. He confirmed the NSA listed an outside provider but did not include what those services were or the responsible party for payment of the services.

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{S5105}	Continued From page 5 The operator failed to ensure the written negotiated service agreement for resident #1267 was based on the functional capacity screening and the service needs included a description of services the resident would receive (fall risk, behavioral management) and failed to identify what services were provided by an outside provider and the responsible party for payment of those services. - Record review for resident #1189 revealed an admission date of 09/17/2019 with diagnoses of dementia, hypertension, rheumatoid arthritis and osteoarthritis. The admission functional capacity screen dated 09/17/19 identified the resident with impaired short-term and long-term memory, memory recall and decision making. She needed physical assistance with all activities of daily living (bathing, dressing, toileting, transfers and walk/mobility) except eating. Licensed nurse/operator B marked she was a fall risk/unsteadiness. She had a medical care provider's orders for physical and occupational therapy (PT/OT) to evaluate and treat. The negotiated service agreement (NSA) dated 09/17/19 and without an amendment, included services under ordered therapies and/or treatments and the section for skilled care, licensed nurse/operator B wrote the name of a medical care/physician provider (usually just the prescriber). The section for outside agency included an unreadable name & associates, the name of a home health agency for PT & OT and the NSA did not identify the party responsible for payment of these outside services.	{S5105}		

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{S5105}	Continued From page 6 As previously cited the resident discharged from the PT/OT services on 11/20/19. Interview on 08/25/2020 at 10:30 AM with licensed nurse/operator B revealed he failed to correct the previously cited deficient practice by a failure to complete an addendum/amendment to the NSA. The operator failed to ensure the written negotiated service agreement for resident #1189 included only the current services the resident received.	{S5105}		
{S5313} SS=E	26-42-205 (g) (3) Over the counter medication (g) (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 26-42-205 (g) (3) The facility reported a census of 4 residents and confirmed they managed medications for all residents. Based on observation and interview the	{S5313}		

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{S5313}	Continued From page 7 operator failed to ensure all over the counter medications which the facility managed were labeled with the full name of the resident by a licensed nurse or a licensed pharmacist for residents #1189 and #1112. Findings included: - On 08/24/2020 at 1:49 PM, Certified Medication Aide (CMA) A opened the only medication cart. Observation revealed over the counter (OTC) medications for resident #1189. The opened bottle of magnesium Oxide was labeled with the resident's first name and last initial. A bottle of iron tablets was labeled with the first name initial and last name. CMA A removed a marking pen from her pocket, and she wrote the resident's name on the bottle. She confirmed she labeled the OTC medications when they come in. - On 08/24/2020 at 1:49 PM, observation also revealed a plastic bag of medications which held approximately 6 bottles of OTC Medications for resident #1112. The OTC bottles were labeled with her full name. Certified medication aide (CMA) A reported she wrote the resident's name on the bottles when the resident admitted. Interview on 08/24/2020 at 1:53 PM with licensed nurse/operator B confirmed his expectation for the CMAs to write the resident's name on their OTC bottles. For all of the above findings, the operator failed to ensure all over the counter medications which the facility managed for residents #1189 and #1112 were labeled with the full name of the resident by a licensed nurse or licensed pharmacist.	{S5313}		

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{S5315}	Continued From page 8	{S5315}		
{S5315} SS=E	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 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)(1)(4)	{S5315}		

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{S5315}	Continued From page 9 The facility reported a census of 4 resident. The facility managed the medications for all 4 residents. The facility identified 3 of the 4 residents as cognitively impaired and idenpendently mobile. Based on observation and interview the operator failed to ensure that licensed nurses and medication aides securely and properly stored medications in a locked medication room, cabinet or medication cart regarding an opened bottle of ibuprofen in an unlocked cabinet of the living room and ensuring certified medication aides/licensed nurses could not administer medications beyond the manufacturer's or pharmacy provider's recommended date of expiration for resident #1214. Findings included: - Observation on 08/24/2020 at 2:21 PM revealed an unlocked cabinet in the living room which had an open bottle of over the counter ibuprofen 200 milligram tablets. Interview with licensed nurse/operator B on 08/24/2020 at 2:21 PM revealed the ibuprofen should not be stored there and was probably a staff members. The operator failed to ensure that licensed nurses and medication aides securely and properly stored medications in a locked medication room, cabinet or medication cart regarding an opened bottle of ibuprofen in an unlocked cabinet of the living room. - Record review for resident #1214 revealed an admission date of 02/10/2020 with diagnoses of dementia, chronic obstructive pulmonary disease	{S5315}		

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{S5315}	Continued From page 10 (COPD), depression, anxiety, diabetes mellitus and hypertension. The admission functional capacity screen (FCS) dated 02/10/2020 identified the resident with cognitive impairment in short-term and long-term memory, memory recall and decision making and she lacked the ability to manage her own medications and treatments. The negotiated service agreement (NSA) dated 02/10/2020 included services of staff to administer the resident medications. Review of the medical care provider's orders revealed orders for the following medications: Budesonide 0.5 milligram(mg)/2 milliliters 1 vial by nebulizer every 12 hours as needed for respiratory failure. Refresh tears 0.5% eye drops instill 1 drop into both eyes every 12 hours as needed for dry eyes Ondansetron 4 mg tablet, dissolve in mouth every 4 hours as needed for nausea/vomiting. On 08/24/2020 at 1:49 PM certified medication aide (CMA) A opened the only medication cart. Observation revealed an open and in-use box of Budesonide nebulizer vials with an expiration date of 06/09/2020, an opened bottle of Odansetron with an expiration date of 02/05/2020 and an open container of Refresh eye drops with an expiration date of 02/05/2020. CMA A confirmed the medications shoud have been reordered and removed from the cart before the expiration date. Interview on 08/25/2020 at 11:30 AM with licensed nurse/operator B confirmed the medications needed removal from the cart and held for destruction when the expiration date was	{S5315}		

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{S5315}	Continued From page 11 reached. He reported staff did not realize this because the medications are used as needed. The operator failed to ensure CMA and licensed nurses could not administer medications beyond the manufacturer's or pharmacy provider's recommended date of expiration for resident #1214.	{S5315}		
{S5316} SS=E	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 12 This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (i) The facility reported a census of 4 residents and facility management of medications for all 4 residents. Based on observation, interview and record review the operator failed to ensure certified medication aides maintained records in sufficient detail for an accurate reconciliation regarding controlled substances for resident #1214 and #1267. Findings included: - On 08/24/2020 at 1:49 PM certified medication aide (CMA) A opened the only medication cart. Observation and reconciliation of the controlled substances in the cart revealed resident #1214's bubble card of Lorazepam 0.5 milligrams (mg) had 13 tablets on the card. Compared to the individual resident's controlled substance record revealed the sheet showed the last removal on 08/22/2020 by CMA C with an amount remaining of 14 tablets. The bubble card of resident #1267's hydrocodone 5mg/acetaminophen 325mg had 29 tablets but the individual controlled substance record showed 30 tablets. CMA A reported she only looked at the cards and not the individual records during that morning shift to shift reconciliation. Review of the resident #1214's August 2020 medication administration record (MAR) revealed the resident received a dose of the Lorazepam every evening with initials on 08/23/2020 as being given. Resident #1267 August 2020 MAR revealed the	{S5316}		

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{S5316}	Continued From page 13 resident received a dose of the hydrocodone/acetaminophen every evening with initials on 08/23/2020 as being given. Review of the Shift count verification form revealed on 08/24/2020 at 7:09 AM CMA A and CMA C signed the status of count as exact with the word yes written in. Interview on 08/24/2020 at 1:53 PM with licensed nurse/operator B confirmed the discrepancy. On 08/25/2020 at 11:00 AM he said he spoke with the staff involved and found the staff did not conducted a reconciliation which he expected them to do at each shift change. The operator failed to ensure certified medication aides maintained records in sufficient detail for an accurate reconciliation regarding controlled substances for resident #1214 and #1267.	{S5316}		
{S5335} SS=E	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437 (a) The facility reported a census of 4 residents.	{S5335}		

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UNIFIED CARE HOME INC	5705 E ROCKHILL WICHITA, KS 67208

(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
{S5335}	Continued From page 14 Licensed nurse/operator B identified 3 of the 4 residents with cognitive impairment and independently mobile. He indicated 2 of the 3 cognitively impaired residents also had wandering behavior (#1214 and #1267). Based on observation, interview, and record review the operator failed to ensure the facility was equipped and maintained to protect the health and safety of residents, personnel, and the public regarding an unlocked chemical, access to a staff's prescribed medications, and an unattended electrical saw plugged into an electrical outlet. Findings included: - On 08/24/2020 at 1:40 PM, during the initial tour of the facility observation revealed an unlocked cabinet under the sink in the residents' common bathroom. Which had an unlabeled/unidentified clear liquid in a spray bottle. When sprayed on the counter the liquid smelled of bleach. Interview on 08/24/2020 at 1:48 PM with licensed nurse/operator B confirmed the unlabeled/unidentified spray bottle contained bleach and water. He confirmed the cabinet should be locked/secured to prevent the cognitively impaired and wandering residents from having access to them. - On 08/24/2020 at 2:28 PM, observation revealed a handbag located in a dining room chair, which had the top of the bag open with visible prescription medication bottles. Interview on 08/24/2020 at 2:50 PM, certified medication aide (CMA) A confirmed the handbag belonged to her and she had it out to take her medications.	{S5335}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	R 08/25/2020

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{S5335}	Continued From page 15 Observation on 08/24/2020 at 3:05 PM revealed the bag remained open on the dining room chair with visible prescription bottles accessible to anyone and no staff in attendance. At 3:30 PM CMA A came to get her bag which had remained on the chair in the dining room open and accessible to anyone for approximately 1 hour. Interview on 08/25/2020 at 11:55 AM with licensed nurse/operator B confirmed the staff were to keep their personal items in a secure area. - On 08/25/2020 at 9:40 AM observation revealed an unlocked door which freely opened into a room under construction. On the floor sat an electrical saw with a circular blade plugged into a power outlet. Interview on 08/25/2020 at 9:54 AM with licensed nurse/operator B confirmed the contracted workers were supposed to put the equipment into a locked room, and the equipment needed locked/secured to prevent the cognitively impaired and wandering residents from having access to them. For all of the above findings, the operator failed to ensure the facility was equipped and maintained to protect the health and safety of residents, personnel, and the public regarding an unlocked chemical, access to a staff's prescribed medications, and an unattended electrical saw plugged into an electrical outlet.	{S5335}		