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 _____	03/04/2020

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 initial licensure survey of the above named home plus facility conducted on 03/02/2020, 03/03/2020 and 03/04/2020.	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)(3) The facility reported a census of 4 residents. The sample included 3 residents. 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 3 sampled residents (#309, #326 and #411) which included a description of services the resident would receive, provider of	S5105		

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

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S5105	Continued From page 1	S5105		

each service and the party responsible for payment if outside resources provide a service.

Findings included:

- Record review on 03/03/2020 at 12:30 PM for resident #411 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). Current problem and risks included falls/unsteadiness, impaired vision, wandering behavior and impaired decision making. The FCS failed to identify the resident with socially inappropriate disruptive behaviors.

The negotiated service agreement (NSA) dated 02/10/2020 included services of staff assist with ADLs; staff provide 3 meals a day and routine housekeeping/laundry services. Staff were to administer the resident medications but failed to indicate an outside provider for administration of the resident's insulin. Licensed nurse/operator A wrote the name of a medical care provider/physician service under the section for skilled nursing services. The section for behavior management and name of outside agency was blank. Under the section for Health and Wellness monitoring the only placed marked was falls/unsteadiness and failed to identify the responsibilities of the staff for assisting the resident with this problem and reduce the risks associated. Licensed nurse/operator A failed to

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S5105	Continued From page 2	S5105		

mark the resident's impaired vision, impaired decision making, wandering and socially inappropriate behaviors.

A medical care provider visit note dated 02/21/2020 indicated the resident had moved from another facility recently and was getting settled into this facility with staff getting to know her personality and behaviors related to dementia. Staff report some agitation and verbal outbursts in the evening with no combative behaviors. The visit notes included a plan to increase the resident's medication Topiramate to 50 milligrams (mg) twice a day for mood disorder.

Review of the nursing notes between 02/10/2020 at 6:15 PM and 03/02/2020 (no time) revealed upon admission the resident received and would continue to receive services from a home health agency for diabetic management (on 02/10/2020 and 02/11/2020). The 02/11/2020 (no time) entry indicated the resident was adjusting well to the new environment had no complaint of pain or discomfort. The next note dated 02/21/2020 (no time) included the resident was seen by a medical care provider with new orders noted and faxed to the pharmacy. The next entry dated 03/02/2020 (no time) noted new order from home health agency to discontinue glimepiride (oral diabetic medication).

The record and the medication administration record book lacked any behavior monitoring records.

Review of the March 2020 medication administration record revealed the resident received the following medications for treatment of mood disorder, anxiety, depression or dementia:

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Topiramate 50 mg by mouth twice a day
Lorazepam 0.5 mg by mouth twice a day
Remeron 30 mg by mouth at bedtime
Pristiq ER (extended release) 50 mg by mouth daily
Exelon 13.3 mg/24 hour patch

She received Basaglar and Novolog insulin for diabetic management administered by home health agency staff.

Observation on 03/02/2020 at 3:30 PM revealed the resident began calling out to another resident "No No No" when the other resident was picking up a pillow from the couch in the living room with the big screen TV. On 03/03/2020 at 12:50 PM a home health agency licensed nurse arrived to check the resident's blood sugar and administer her routine insulin. On 03/03/2020 at 2:00 PM the resident displayed socially inappropriate disruptive behavior by yelling out at staff to "Shut up" while the staff were having a conversation then she yelled at another resident to stop folding up the cloth furniture cover. On 03/03/2020 twice during the afternoon and then again at 3:00 PM the resident spontaneously began to cry. When the surveyor asked the resident, what was wrong she said she was afraid and when asked what she was afraid of she said she didn't know. She then looked out the patio doors and quit crying. At 4:35 PM she again had behaviors of verbal aggression towards another resident who was messing with the couch furniture cover calling out "Stop that, No No" when certified staff B came from the kitchen area and redirected both residents.

Interview on 03/03/2020 at 9:09 AM with certified staff C revealed the resident displayed "bossy" behaviors towards other residents sometimes.

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She seems to have more behaviors in the afternoon/evening. She said she just talked with the resident and the resident usually calmed down.

Interview on 03/03/2020 at 5:05 PM with licensed nurse/operator A confirmed the NSA failed to include the resident's diabetic management provider by an outside source, payment for the provider, the resident's behaviors and specific responsibilities of staff to manage the resident's fall risk.

The operator failed to ensure the written negotiated service agreement for resident #411 was based on the functional capacity screening and the service needs which included a description of services the resident would receive (fall risk, behavioral management), provider of each service (home health agency) and the party responsible for payment if outside resources provide a service.

- Record review on 03/03/2020 at 11:57 AM for resident #326 revealed an admission date of 09/17/2020 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 A marked she was a fall risk/unsteadiness. She had orders for physical and occupational therapy (PT/OT) to evaluate

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S5105	Continued From page 5 and treat. The negotiated service agreement (NSA) dated 09/17/19 and without an amendment, included services of physical assistance by staff for ADLs, staff prepared meals, set-up assistance and supervision with meals. Staff administered the resident's medications. Under ordered therapies and/or treatments and section for skilled care licensed nurse/operator A wrote the name of a medical care/physician provider. The section for outside agency included an unreadable name & associates, the name of a home health agency for PT & OT. The NSA did not identify the party responsible for payment of these outside services. Review of the nursing notes revealed on 09/18/19 at 3:00 PM called and faxed orders for PT/OT to home health agency. Review of the visit notes by the home health agency for PT/OT revealed the resident began services on 09/23/19 and discharged from the services on 11/20/19. Observation on 03/02/2020 at 3:35 PM revealed the resident ambulating independently with a 4 wheeled walker in the living room with the big screen TV. Interview on 03/03/2020 at 4:30 PM with licensed nurse/operator A confirmed the he failed to include the party responsible for payment of the outside services and failed to amend the NSA when the outside services stopped. The operator failed to ensure the written negotiated service agreement for resident #326 included the party responsible for payment if	S5105		

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S5105	Continued From page 6 outside resources provide a service and an amendment when the services stopped. - Record review on 03/03/2020 at 9:54 AM for resident #309 revealed an admission date of 12/26/19 with diagnoses of hypertension, coronary artery disorder, history of a CVA (cerebral vascular accident/stroke) with left hemiplegia, osteoarthritis, and chronic pain. The admission functional capacity screen (FCS) dated 12/26/19 indicated the resident had impaired short and long-term memory as well as memory recall with intact decision-making abilities. He needed physical assistance with all activities of daily living (bathing, dressing, toileting, transfers and walk/mobility) except eating. He was at risk for falls and used an electric scooter/wheelchair for mobility. The FCS indicated the resident received hospice services. The negotiated service agreement 12/26/19 and without an amendment, included services of physical assistance by staff for ADLs, use of a scooter wheelchair, staff preparation of meals and administration of medications. Under ordered therapies and/or treatments and section for skilled care licensed nurse/operator A wrote the name of a medical care/physician provider. The section for outside agency included the name of the hospice provider but failed to identify the party responsible for payment of these outside services. A medical care provider visit note dated 02/21/2020 indicated the resident was discharged from hospice and worked with therapy over the last month.	S5105		

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S5105	Continued From page 7 Review of the nursing notes revealed an entry on 12/26/19 at 4:15 PM indicated the resident received services from an outside hospice provider. Subsequent notes dated 12/27/19 at 11:30 AM, 12/31/19 at 4:00 PM, 01/03/2020 at 11:00 AM and 02/21/2020 failed to include any changes in the provider of outside services. Review of the visit notes from the outside provider revealed on 01/17/2020 the resident discharged from hospice services and began physical and occupation therapy (PT/OT). The resident discharged from OT services on 01/17/2020 and PT services on 02/13/2020. Interview on 03/03/2020 at 4:30 PM with licensed nurse/operator A confirmed the he failed to included the party responsible for payment of the outside services and failed to amend the NSA when the hospice services stopped and PT/OT started and then again when the OT & PT services stopped. The operator failed to ensure the written negotiated service agreement for resident #309 included the party responsible for payment if outside resources provide a service and an amendment when the services stopped or started.	S5105		
S5155 SS=D	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S5155		

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S5155	Continued From page 8	S5155		

This REQUIREMENT is not met as evidenced by:
KAR 26-42-204 (a)

The facility reported a census of 4 residents. The sample included 3 residents. Based on observation, interview and record review licensed nurse/operator A failed to provide or coordinate the provision of necessary health care services to meet the needs for 1 of 3 residents sampled (#411) regarding cognitive needs, fall risk, wandering and socially inappropriate/disruptive behaviors.

Findings included:

- Record review on 03/03/2020 at 12:30 PM for resident #411 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). Current problem and risks included falls/unsteadiness, impaired vision, wandering behavior and impaired decision making. The FCS failed to identify the resident with socially inappropriate disruptive behaviors.

The negotiated service agreement (NSA) dated

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02/10/2020 included services of staff assist with ADLs; staff provide 3 meals a day and routine housekeeping/laundry services. Staff were to administer the resident medications. The section for behavior management was blank. Under the section for Health and Wellness monitoring included a check mark for falls/unsteadiness, listed the name of a medical care provider/physician service, facility staff and failed to identify the responsibilities of the staff for assisting the resident with this problem to reduce the risk. Licensed nurse/operator A failed to mark the resident's impaired vision, impaired decision making, wandering and socially inappropriate behaviors.

The undated resident service plan directed staff to administer the resident's medications, assist with dressing, bathing, toileting, provide max assist with transfers and mobility. The resident service plan did not identify or include interventions to address the resident's cognitive needs, fall risk, wandering behavior, or socially inappropriate/disruptive behaviors.

A medical care provider visit note dated 02/21/2020 indicated the resident had moved from another facility recently and was getting settled into this facility with staff getting to know her personality and behaviors related to dementia. Staff report some agitation and verbal outbursts in the evening with no combative behaviors. The visit notes included a plan to increase the resident's medication Topiramate to 50 milligrams (mg) twice a day for mood disorder.

Review of the nursing notes between 02/10/2020 at 6:15 PM and 03/02/2020 (no time) revealed upon admission the resident received and would continue to receive services from a home health

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S5155	Continued From page 10	S5155		

agency for diabetic management (on 02/10/2020 and 02/11/2020). The 02/11/2020 (no time) entry indicated the resident was adjusting well to the new environment had no complaint of pain or discomfort. The next note dated 02/21/2020 (no time) included the resident was seen by a medical care provider with new orders noted and faxed to the pharmacy. The next entry dated 03/02/2020 (no time) noted new order from home health agency to discontinue glimepiride (oral diabetic medication).

The record and the medication administration record book lacked any behavior monitoring records.

Review of the March 2020 medication administration record revealed the resident received the following medications for treatment of mood disorder, anxiety, depression or dementia:
Topiramate 50 mg by mouth twice a day
Lorazepam 0.5 mg by mouth twice a day
Remeron 30 mg by mouth at bedtime
Pristiq ER (extended release) 50 mg by mouth daily
Exelon 13.3 mg/24 hour patch

Observation on 03/02/2020 at 3:30 PM revealed the resident began calling out to another resident "No No No" when the other resident was picking up a pillow from the couch in the living room with the big screen TV. On 03/03/2020 at 12:50 PM a home health agency licensed nurse arrived to check the resident's blood sugar and administer her routine insulin. On 03/03/2020 at 2:00 PM the resident displayed socially inappropriate disruptive behavior by yelling out at staff to "Shut up" while the staff were having a conversation then she yelled at another resident to stop folding

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S5155	Continued From page 11 up the cloth furniture cover. On 03/03/2020 twice during the afternoon and then again at 3:00 PM the resident spontaneously began to cry. When the surveyor asked the resident, what was wrong she said she was afraid and when asked what she was afraid of she said she didn't know. She then looked out the patio doors and quit crying. At 4:35 PM she again had behaviors of verbal aggression towards another resident who was messing with the couch furniture cover calling out "Stop that, No No" when certified staff B came from the kitchen area and redirected both residents. Interview on 03/03/2020 at 9:09 AM with certified staff C revealed the resident displayed "bossy" behaviors towards other residents sometimes. She seems to have more behaviors in the afternoon/evening. She said she just talked with the resident and the resident usually calmed down. Interview on 03/03/2020 at 5:05 PM with licensed nurse/operator A confirmed the resident service plan lacked identification of and interventions for cognitive needs, fall risk, wandering or socially inappropriate/disruptive behaviors. Licensed nurse/operator A failed to provide or coordinate the provision of necessary health care services to meet the needs for this resident regarding cognitive needs, fall risk, wandering and socially inappropriate/disruptive behaviors.	S5155		
S5185 SS=D	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each	S5185		

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resident ' s negotiated service agreement.
(b) The supervisory responsibility for dietetic services shall be assigned to one employee.
(c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian.

This REQUIREMENT is not met as evidenced by:
KAR 26-42-206 (c)

The facility reported a census of 4 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to ensure staff provided the mechanically altered diet for resident #326 in accordance with the negotiated service agreement, a medical care provider's order and instructions from a medical care provider or licensed dietitian.

Findings included:

- Record review on 03/03/2020 at 11:57 AM for resident #326 revealed an admission date of 09/17/2020 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

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and decision making. She needed physical assistance with all activities of daily living (bathing, dressing, toileting, transfers and walk/mobility) except eating which required supervision.

The negotiated service agreement (NSA) dated 09/17/19 and without an amendment, included services of physical assistance by staff for ADLs, staff prepared meals, served a regular liberalized diet and provided set-up assistance and supervision with meals. She had service needs for cognitive impairment in short and long-term memory, memory recall and decision making but did not indicate what those services consisted of.

The resident service plan dated 09/17/19 directed staff the resident needed a mechanical soft diet and meal assistance of cutting with handwritten 1 staff to assist to prepare meals and cut into small pieces.

A medical care provider's order signed 10/18/19 included a mechanical soft diet.

The record lacked any instruction from a medical care provider or licensed dietitian on how to prepare/serve a mechanical soft diet specific for the resident.

Review of the nursing notes between 09/17/19 at 2:05 PM thru 02/26/2020 at 10:26 AM, revealed an entry on 09/17/19 at 2:05 PM resident admitted today, alert with forgetfulness ... she had no teeth and no dentures ... regular diet ... Entries between 09/17/19 at 2:05 PM and 09/24/19 at 10:00 AM did not include any information about the resident's food consumption or abilities related to food. On 09/24/19 at 10:00 AM the note said the resident was up and eating breakfast. On

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09/26/19 at 6:20 PM ... ate 75%. On 09/29/19 at 6:00 PM resident ate 75%. Notes between 09/29/19 at 6:00 PM and 10/06/19 at 4:00 PM lacked any information about the resident's meal consumption or eating abilities. On 10/06/19 at 4:00 PM resident ate about 80% of the meal during lunch. The note did not included information about her eating ability. Notes between 10/06/19 at 4:00 PM and 10/18/19 at 11:35 AM lacked any information about the resident's eating ability. On 10/18/19 at 11:35 AM medical care provider D visited, resident received the influenza vaccine ... also noted new orders, faxed to pharmacy and family notified. The next note was dated 10/31/19 at 10:30 AM and identified as a monthly care plan review - with no changes noted. The note did not reflect any information about the resident's diet order, diet served or her eating abilities. A note on 11/29/19 and 12/31/19 were also monthly care plan review note and noted no changes and without any information on her eating abilities. Notes between 12/31/19 and 02/25/2020 did not include information related to her eating abilities. On 2/25/2020 at 11:00 AM licensed nurse/operator A wrote the resident at 100% of breakfast but did not indicated the resident's eating abilities.

Observation on 03/02/2020 at 2:00 PM revealed the resident seated at the dining room table independently eating a bowl of shrimp alfredo. The resident would spit out the small (approximately 1/2 inch) pieces of shrimp and placed them on the table. She ate the noodles and the green vegetable in the dish without difficulty. Interview with direct care staff B revealed the resident had no teeth and could not chew the shrimp. She offered the resident something else, but the cognitively impaired resident just smiled and continued to eat the

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S5185	Continued From page 15 noodles. On 03/03/2020 at 12:55 PM direct care staff B served the resident a whole hotdog on a bun with a serving of french fries. She then asked the resident if she wanted ketchup showing her the bottle and the resident said yes. She applied ketchup to the hot dog and the fries. The resident picked up a french frie, placed it in her mouth and moved the food around in her mouth for some time then swallowed. At 1:04 PM the resident picked up the hotdog/bun and took a small bite mushing and moving the food around in her mouth. The resident continued eating until approximately 2:00 PM. Interview on 03/03/2020 at 1:06 PM with direct care staff B revealed none of the residents were on a special diet. She said the resident did not have any teeth so she will cut up her food for her. Did not cut up the hotdog so the resident could pick it up with her hand. Interview on 03/03/2020 at 2:25 PM with licensed nurse/operator A confirmed the resident had a medical care provider's order for a mechanical soft diet, he confirmed the NSA was not amended when the diet order changed. He confirmed the record lacked instructions specific to the ordered diet and the resident's needs. The operator failed to ensure staff provided the mechanically altered diet for resident #326 in accordance with the negotiated service agreement, a medical care provider's order and instructions from a medical care provider or licensed dietitian.	S5185		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education	S5215		

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S5215	Continued From page 16 (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)(1)(2)(3) The facility reported a census of 4 residents. Based on record review and interview the operator failed to ensure disaster and emergency preparedness by ensuring the performance of orientation of new employees at the time of employment to the home's emergency plan; education of each resident upon admission to the home regarding the emergency procedures and a quarterly review of the home's emergency plan with employees and residents. Findings included: - On 03/02/2020 licensed nurse/operator A confirmed the facility received admitted the first resident on 09/17/19. He provided a list of 6 employees hired since 09/17/19.	S5215		

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S5215	Continued From page 17 Personnel record review revealed none of the records included evidence of staff orientation for the emergency management plan at the time of hire. On 03/02/2020 at 4:20 PM revealed within the facility policy and procedure book was the emergency disaster plan which included all required elements except missing resident. A request at 4:55 PM for evidence of employee orientation to the facility's emergency plan was made and licensed nurse/operator A reported the documentation would be in the employee's personnel record and residents would be in the chart. Personnel record review conducted on 03/03/2020 at 10:30 AM revealed the sampled newly hired direct care staff B, C, E and F had no evidence of being trained in the facility's emergency disaster plan upon employment. Resident record review on 03/03/2020 for resident #326 admitted on 09/17/19 and resident #411 admitted on 2/10/2020 revealed neither resident had evidence of orientation to the facility's emergency disaster plan. Upon request on 03/03/2020 for a quarterly review in the emergency disaster plan with resident #326 who admitted on 09/17/19 none was provided. Interview on 03/03/2020 at 11:15 AM with licensed nurse/operator A confirmed the personnel files for direct care staff B, C, E and F lacked evidence of orientation to the emergency management plan at the time of employment and 2 of 3 sampled residents (#236 and #411) at the time of admission. He confirmed a lack of	S5215		

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S5215	Continued From page 18 documentation for a quarterly review of the emergency management plan with residents, and/or responsible parties and only and with employees since admitted the first resident 09/17/19 (a 4th quarter review for 2019 as required). The operator failed to ensure disaster and emergency preparedness by ensuring the performance of orientation of new employees at the time of employment to the home's emergency plan; education of each resident upon admission to the home regarding the emergency procedures and a quarterly review of the home's emergency plan with employees and residents.	S5215		
S5246 SS=F	26-42-105 (c) Resident Record Safeguards (c) Each administrator or operator shall ensure the safeguarding of resident records against the following: (1) Loss; (2) destruction; (3) fire; (4) theft; and (5) unauthorized use. This REQUIREMENT is not met as evidenced by: KAR 26-41-105 (c)(5) The facility reported a census of 4 residents. Based on observation, interview and record review the operator failed to safeguard the residents' records against the possible unauthorized use by having charts, notebooks and file folders on shelves and in unlocked lower cabinets located in the common living room area. The charts, notebooks and file folders included	S5246		

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resident protected information for 3 sampled residents (#309, #326, #411) 91 current resident (#422) and 1 former resident (#510).

Findings included:

- On 03/02/2020 during the initial tour which began at 2:00 PM observation revealed a built-in wall cabinet in the living room with the big screen TV. The cabinet had multiple shelves and lower cabinets with doors. On the shelves were 9 notebooks and a folder from an outside provider of services for former resident #510 with resident protected information. Further review of the notebooks at 3:35 PM revealed a notebook labeled dialysis hand-off with contents of former resident #510's personal information, a home health agency file folder for resident #309 and former resident #510 with information about the resident's health condition. A notebook with information from the facility's pharmacy of delivery sheets which included resident names, and medications delivered for resident #309, #326, #411, and #422. A notebook for the ADLs (activities of daily living) provided to residents and Medicaid required charting for #309, #326, #411, #422 and former resident #510.

In the unlocked lower cabinets were the medical charts for residents #309, #326, #411, #422 and former resident #510. Also, in the unlocked cabinet were file folders, papers and unopened mail for residents #309, #326, #411, #422 and former resident #510 with resident protected information.

Interview on 03/02/2020 at 4:00 PM with licensed nurse/operator A confirmed the records observed were records for the residents and were considered confidential protected documents and

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S5246	Continued From page 20 should be secured from unauthorized use. The operator failed to safeguard the residents' records against the possible unauthorized use by having charts, notebooks and file folders on shelves and in unlocked lower cabinets located in the common living room area. The charts, notebooks and file folders included resident protected information for 3 sampled residents (#309, #326, #411) 91 current resident (#422) and 1 former resident (#510).	S5246		
S5251 SS=E	26-42-105 (f) (11) Resident Records 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. This REQUIREMENT is not met as evidenced by: KAR 26-42-105 (f)(11) The facility reported a census of 4 resident. The sample included 3 residents. Based on observation, interview and record review licensed nurse/operator A failed ensure the 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 for 3 of 3 sampled residents (#309, #326 and #411) regarding behaviors, foot pain, mood disturbances and adverse reaction to medication. Findings included:	S5251		

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S5251	Continued From page 21 - Record review on 03/03/2020 at 12:30 PM for resident #411 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). Current problem and risks included falls/unsteadiness, impaired vision, wandering behavior and impaired decision making. The FCS failed to identify the resident with socially inappropriate disruptive behaviors. The negotiated service agreement (NSA) dated 02/10/2020 included services of staff assist with ADLs, staff provide 3 meals a day and routine housekeeping/laundry services. Staff were to administer the resident medications. The section for behavior management was blank. Under the section for Health and Wellness monitoring included a check mark for falls/unsteadiness, listed the name of a medical care provider/physician service, facility staff and failed to identify the responsibilities of the staff for assisting the resident with this problem to reduce the risk. Licensed nurse/operator A failed to mark the resident's impaired vision, impaired decision making, wandering and socially inappropriate behaviors. The undated resident service plan directed staff to administer the resident's medications, assist with dressing, bathing, toileting, provide max assist with transfers and mobility. The resident service plan did not identify or include	S5251		

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interventions to address the resident's cognitive needs, fall risk, wandering behavior, or socially inappropriate/disruptive behaviors.

A medical care provider visit note dated 02/21/2020 indicated the resident had moved from another facility recently and was getting settled in to this facility with staff getting to know her personality and behaviors related to dementia. Staff report some agitation and verbal outbursts in the evening with no combative behaviors. The visit notes included a plan to increase the resident's medication Topiramate to 50 milligrams (mg) twice a day for mood disorder.

Review of the nursing notes between 02/10/2020 at 6:15 PM and 03/02/2020 (no time) revealed upon admission the resident received and would continue to receive services from a home health agency for diabetic management (on 02/10/2020 and 02/11/2020). The 02/11/2020 (no time) entry indicated the resident was adjusting well to the new environment had no complaint of pain or discomfort. The next note dated 02/21/2020 (no time) included the resident was seen by a medical care provider with new orders noted and faxed to the pharmacy. The next and last entry dated 03/02/2020 (no time) noted new order from home health agency to discontinue glimepiride (oral diabetic medication).

The record and the medication administration record book lacked any behavior monitoring records.

Observation on 03/02/2020 at 3:30 PM revealed the resident began calling out to another resident "No No No" when the other resident was picking up a pillow from the couch in the living room with the big screen TV. On 03/03/2020 at 12:50 PM a

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home health agency licensed nurse arrived to check the resident's blood sugar and administer her routine insulin. On 03/03/2020 at 2:00 PM the resident displayed socially inappropriate disruptive behavior by yelling out at staff to "Shut up" while the staff were having a conversation then she yelled at another resident to stop folding up the cloth furniture cover. On 03/03/2020 twice during the afternoon and then again at 3:00 PM the resident spontaneously began to cry. When the surveyor asked the resident, what was wrong she said she was afraid and when asked what she was afraid of she said she didn't know. She then looked out the patio doors and quit crying. At 4:35 PM she again had behaviors of verbal aggression towards another resident who was messing with the couch furniture cover calling out "Stop that, No No" when certified staff B came from the kitchen area and redirected both residents.

Interview on 03/03/2020 at 9:09 AM with certified staff C revealed the resident displayed "bossy" behaviors towards other residents sometimes. She seems to have more behaviors in the afternoon/evening. She said she just talked with the resident and the resident usually calmed down.

Interview on 03/03/2020 at 2:35 PM with licensed nurse/operator A confirmed the nursing notes or any other documentation in the resident's record accurately reflected the resident's behaviors and need for the Topiramate medications for the resident's mood disorder. He confirmed the record lacked information to reflect the outcome of the medication increase and the resident's mood disorder.

Licensed nurse/operator A failed to ensure the

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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 for this resident regarding behaviors, need to increase medications and results of the increased medication.

- Record review on 03/03/2020 at 9:54 AM for resident #309 revealed an admission date of 12/26/19 with diagnoses of hypertension, coronary artery disorder, history of a CVA (cerebral vascular accident/stroke) with left hemiplegia, osteoarthritis, and chronic pain.

The admission functional capacity screen (FCS) dated 12/26/19 indicated the resident had impaired short and long-term memory as well as memory recall with intact decision-making abilities. He needed physical assistance with all activities of daily living (bathing, dressing, toileting, transfers and walk/mobility) except eating. He was at risk for falls and used an electric scooter/wheelchair for mobility.

The negotiated service agreement 12/26/19 and without an amendment, included services of physical assistance by staff for ADLs, use of a scooter wheelchair, staff preparation of meals and administration of medications.

The resident care plan dated 12/26/19 directed staff to administer all resident's medications, assist the resident with all activities of daily living. He needed assistance to transfer from the bed to the electric scooter/wheelchair and then could operate the scooter independently

Medical care provider D's visit note dated 02/21/2020 indicated facility staff requested the visit to evaluate the resident's report of his feet

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hurt. He said several area on the bottom of his feet hurt when he put weight on them. He does not walk much but had been working with therapy and was getting up more. Medical care provider D ordered Aquaphor or Eucerin lotion to feet daily at bedtime and PRN (as needed), recommend a podiatry visit for toenails, lab orders, increase the gabapentin to 100 milligrams by mouth twice a day for neuropathy pain and Tylenol 650 milligrams by mouth every 4 hours PRN pain.

Review of the nursing notes revealed an admission entry on 12/26/19 at 4:15 PM which indicated the resident was alert and forgetful but able to make needs known. The resident transferred with assist of 1 staff to the scooter and no mention of any pain. Next entry on 12/27/19 at 11:30 AM no complaints of pain or discomfort. Next entry on 12/31/19 at 4:00 PM seen by medical care provider D no new orders. Next entry 01/05/2020 at 11:00 AM family visited...resident had no complaints of pain or discomfort. Next and last entry dated 02/21/2020 at (unreadable time) seen by medical care provider D, new orders noted and faxed to the pharmacy and family notified. No notes about the resident's reported foot pain, assessment by a nurse, the specific orders on 02/21/2020 to address foot pain or the outcome of the increase in the gabapentin on the resident's foot pain.

Interview on 03/03/2020 at 5:05 PM with licensed nurse/operator A confirmed the record lacked information regarding the resident complaint of foot pain, assessment by a nurse, and the outcome of the increased gabapentin for the resident foot pain.

Review of the nursing notes revealed an entry on 12/26/19 at 4:15 PM indicated the resident

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received services from an outside hospice provider. Subsequent notes dated 12/27/19 at 11:30 AM, 12/31/19 at 4:00 PM, 01/03/2020 at 11:00 AM and 02/21/2020 failed to include any changes in the provider of outside services.

Licensed nurse/operator A failed to ensure the 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 for residents #309 regarding foot pain with medication adjustment.

- Record review on 03/03/2020 at 11:57 AM for resident #326 revealed an admission date of 09/17/2020 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 and staff to administer her medications. She was not marked as having any behaviors.

The negotiated service agreement (NSA) dated 09/17/19 and without an amendment, included services of physical assistance by staff for ADLs, staff prepared meals, set-up assistance and supervision with meals. Staff administered the resident's medications and she was not marked as needing behavioral management.

The resident care plan dated 09/17/19 directed staff to assist the resident with all activities of

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daily living, administer her medications and no indicators of behavioral needs.

Review of the medical care provider's orders revealed on 10/18/19 medical care provider D prescribed gabapentin 100 milligrams (mg) by mouth twice a day (BID) for mood stabilization. On 12/31/19 medical care provider D prescribed increase gabapentin to 200 mg by mouth 3 times day then in 2 weeks increase to 300 mg. On 01/20/2020 medical care provider D prescribed decrease gabapentin to 200 mg 3 times a day.

Review of the nursing notes between 09/17/19 at 2:05 PM (admission note) through 10/16/19 at 1:30 PM with no of the notes mentioning the resident having any mood problems, she had no complaints of pain or discomfort. On 10/18/19 at 11:35 AM licensed nurse/operator A wrote medical care provided D visited, influenza vaccine administered, vital signs listed, noted new orders, faxed to pharmacy and family notified. Nothing about the resident having mood issues and need for the start of gabapentin. The next note was dated 10/31/19 at 10:30 AM regarding a monthly care plan review with no noted changes. Resident alert with dementia, easily redirected and needed maximum assist with activities of daily living ... no complaint of pain or discomfort. The next entry dated 11/29/19 at 10:00 AM was also a monthly care plan review note and did not indicate the resident had any mood problems. The next entry on 12/31/19 at 4:30 PM resident was seen by medical care provider D with new order noted and faxed to the pharmacy and family notified. Also reviewed the care plan with no changes noted ... and signed by licensed nurse/operator A. The notes lacked any evidence the resident was having any mood issues, did she respond well to the start of the

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UNIFIED CARE HOME INC	5705 E ROCKHILL WICHITA, KS 67208

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gabapentin back on 10/18/19 and what were the new orders on 12/31/19 ordered to address (increase of the gabapentin as above). The next note dated 01/20/2020 at 8:30 AM by licensed nurse/operator A read resident has been decreased mobility, spoke with the medical care provider D who ordered to decrease the gabapentin to 200 mg 3 times a day for mood stabilization... No notes to indicate the resident was having trouble with mobility or signs of adverse reaction to the increased dosage of the gabapentin ordered on 12/31/19. The next note dated 02/29/2020 at 2:15 PM had nothing about the resident's tolerance or return to previous status following the reduction of the gabapentin on 01/20/2020.

Observation on 03/02/2020 at 2:00 PM revealed the resident seated at the dining room table calmly eating independently. When she was done eating, she got up from the table using a 4 wheeled walker and ambulated to the living room with the big screen TV. She watched TV for a while seated on the couch then got up and walked about for a little bit. She did not display any mood disturbances. Observation on 03/03/2020 at 8:45 AM revealed the resident seated at the dining table calmly eating breakfast independently. At 10:59 AM direct care staff B assisted, guided, cued the resident to the bathroom. The resident had no mood disturbances or resistance to care provided.

Interview on 03/03/2020 at 2:35 PM with licensed nurse/operator A confirmed the nursing notes lacked information to show the resident had mood disturbances, needed the medication gabapentin or the increase in the gabapentin and no information about an adverse reaction to the increased gabapentin.

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S5251	Continued From page 29 licensed nurse/operator A failed ensure the 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 for residents #326 regarding mood disturbances with medication start, increase and adverse reaction to the increased medication.	S5251		
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 resident. The sample included 3 residents. Based on observation, interview and record review the operator failed to ensure all over the counter medications which the facility managed for residents were labeled with the full name of the resident for 2 of 3 sampled resident (#309 and	S5313		

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S5313	Continued From page 30 #326). Findings included: - On 03/02/2020 at 2:44 PM licensed nurse/operator A provided a resident roster which identified facility management of medications for resident #309 and #326. On 03/02/2020 at 4:08 PM licensed nurse/operator A opened the only medication cart. Observation revealed over the counter (OTC) medications which were not labeled with the resident's full name: Licensed nurse/operator A identified the following OTC medications which did not have the resident's name on them as belonging to resident #326: (1) bottle of stool softener 100 milligrams (mg) opened and no name Iron tablets 325 mg opened no name Magnesium Oxide 400 mg opened and no name Licensed nurse/operator A identified the following OTC medications which did not have the resident's name on them as belonging to resident #309 Mucus relief (guaifenesin) 400 mg opened with no name (1) larger bottle as a Walgreens brand of acetaminophen 500 mg opened with no name The cart also had a large bottle and a smaller bottle of acetaminophen 500 mg which were opened and had no name, but licensed nurse/operator A did not know who those medications belonged to. Interview on 03/02/2020 at 4:08 PM with licensed nurse/operator A confirmed the OTC medications	S5313		

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S5313	Continued From page 31 for the residents were not labeled with his/her full name as required. The operator failed to ensure all over the counter medications were labeled with the full name of the resident.	S5313		
S5315 SS=F	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 '	S5315		

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S5315	Continued From page 32 s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (h)(1)(4) The facility reported a census of 4 resident. The facility managed the medications for all 4 residents. 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 refrigeration for 3 residents (#411, #422 and former resident #510), and ensuring licensed nurses could not administer insulin beyond the manufacturer's or pharmacy provider's recommended date of expiration for resident #411. Findings included: - On 03/02/2020 at 2:29 PM observation revealed a small counter style refrigerator which sat on the floor in the front living room by the front door of the facility. The refrigerator did not have locking mechanism and freely opened. Staff stored inside the refrigerator 3 bottles of Lantus insulin for former resident #510, insulin pens for resident #411 (1 Novolog) and #422 (2 Novolog and 2 Levemir), 2 partial boxes and 1 full box of unit dose Brovana respiratory medication for resident #411. Licensed nurse/operator A on 03/02/2020 at 2:44 PM provided the resident roster which indicated the facility managed the medications for resident #411 and #422.	S5315		

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S5315	Continued From page 33 Interview on 03/02/2020 at 2:35 PM with licensed nurse/operator A confirmed the medication refrigerator lacked a locking mechanism. He confirmed having wandering residents and the refrigerator should be locked when it has medications in it. 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. - Record review on 03/03/2020 at 12:30 PM for resident #411 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). She lacked the ability to manage her own medications and treatments. The negotiated service agreement (NSA) dated 02/10/2020 included services of staff assist with ADLs; staff provide 3 meals a day and routine housekeeping/laundry services. Staff were to administer the resident medications. The undated resident service plan directed staff to administer the resident's medications, assist with dressing, bathing, toileting, provide max assist with transfers and mobility.	S5315		

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S5315	Continued From page 34 Review of the medical care provider's orders revealed an order for Basaglar 100 unit/milliliter Kwik Pen with directions to inject 10 units sub cutaneous every day for diabetes mellitus. On 03/02/2020 at 4:08 PM licensed nurse/operator A opened the only medication cart. Observation revealed an open and in-use Basaglar insulin Kwik Pen with an open date of 01/18/2020 for the resident. Licensed nurse/operator A confirmed the open date on the insulin pen was to ensure the medication was discarded timely. The manufacturer at basaglar.com recommended once a pen was opened, store it at room temperature and throw it away after 28 days. The operator failed to ensure licensed nurses could not administer insulin beyond the manufacturer's or pharmacy provider's recommended date of expiration for resident #411.	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	S5316		

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S5316	Continued From page 35 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. 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 have a system in place to ensure licensed nurses and certified medication aides maintained records in sufficient detail for an accurate reconciliation regarding controlled substances for resident #326, #411 and #422. Findings included: - Observation on 03/02/2020 at 3:30 PM licensed nurse/operator A and certified medication aide (CMA) B began reconciliation of the controlled substances. The nurse looked and the individual resident bubble cards and CMA B looked at the individual resident record opened the only medication cart. When they were done neither of the staff signed a document to verify the	S5316		

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S5316	Continued From page 36 controlled substance reconciliation was accurate. Review of the notebook for the controlled substance records revealed a separate page for each controlled substance for residents #326, #411 and #422. The book had no record with signatures for the reconciliation between the different staff who administered the controlled substances. Interview on 03/02/2020 at 3:35 PM licensed nurse/operator A confirmed he had not implemented a shift to shift reconciliation form because they did not really have shift to shift when a CMA or nurse was on duty. He staffed with certified nurse aides and he would come in to do the medication pass. Review of the individual controlled substance sheet for resident #422 revealed 4 different staff had signed removal of alprazolam 0.25 milligrams between 02/26/2020 and 03/02/2020. The facility's undated policy for narcotic (controlled substance) counting at shift change directed staff to sign the "narcotic count sheet", at the beginning of each resident's section. When you are coming on duty and going off duty you should be initialing to verify that the count was done. The operator failed to have a system in place to ensure licensed nurses and certified medication aides maintained records in sufficient detail for an accurate reconciliation regarding controlled substances for resident #326, #411 and #422.	S5316		
S5320 SS=E	26-42-205 (k) Medication Clinical Records	S5320		

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S5320	Continued From page 37 (k) Clinical record. The administrator or operator, or the designee, shall ensure that the clinical record of each resident for whom the home manages the resident ' s medication or prefills medication containers or syringes contains the following documentation: (1) A medical care provider ' s order for each medication; (2) the name of the pharmacy provider of the resident ' s choice; (3) any known medication allergies; and (4) the date and the 12-hour or 24-hour clock time any medication is administered to the resident. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (k)(4) The facility reported a census of 4 residents and facility management of medications for all 4 residents. Based on observation, interview and record review for 3 of 3 residents (#309, #326 and #411) the operator failed to ensure the residents' clinical record included the date and a 12-hour or 12-hour clock time for any medication administered to the resident. Findings included: - Record review on 03/03/2020 at 11:57 AM for resident #326 revealed an admission date of 09/17/2020 with diagnoses of dementia, hypertension, rheumatoid arthritis and osteoarthritis.	S5320		

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S5320	Continued From page 38 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. She lacked the ability to manage her own medications. The negotiated service agreement (NSA) dated 09/17/19 and without an amendment, included services of physical assistance by staff for ADLs, staff prepared meals, set-up assistance and supervision with meals. Staff administered the resident's medications. The resident service plan dated 09/17/19 directed staff to administer the medications daily. Review of the March 2020 medication administration record revealed medication administration times of AM (morning), noon, PM (evening) and HS (bedtime). Observation on 03/02/2020 at 2:11 PM revealed certified medication aide (CMA) B administering medications. She reported they were the noon medications. On 03/03/2020 at 1:15 PM observation revealed CMA B administering medications which she said were the noon medications. Interview on 03/03/2020 at 1:47 PM with CMA B revealed she was directed the resident have a liberalized medication pass times with a range for example in the morning can give between 7 am and 9 am and the noon would be 11 am to 1 pm for the hour before and the hour after the scheduled time.	S5320		

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S5320	Continued From page 39 Interview on 03/03/2020 at 1530 PM with licensed nurse/operator A revealed he planned for the residents to have a liberalized medication pass time of AM, noon, PM and HS. He reported an expectation for the noon medications to be given at noon. - Record review on 03/03/2020 at 9:54 AM for resident #309 revealed an admission date of 12/26/19 with diagnoses of hypertension, coronary artery disorder, history of a CVA (cerebral vascular accident/stroke) with left hemiplegia, osteoarthritis, and chronic pain. The admission functional capacity screen (FCS) dated 12/26/19 indicated the resident had impaired short and long-term memory as well as memory recall with intact decision-making abilities. He needed physical assistance with all activities of daily living (bathing, dressing, toileting, transfers and walk/mobility) except eating. He lacked the ability to manage his own medications The negotiated service agreement 12/26/19 and without an amendment, included services of physical assistance by staff for ADLs, use of a scooter wheelchair, staff preparation of meals and administration of medications. The resident care plan dated 12/26/19 directed staff to administer the resident's medications daily. Review of the March 2020 medication administration record revealed medication administration times of AM (morning), PM (evening) and HS (bedtime). The Mucinex had time frames of 8:00 AM and 8:00 PM (this was	S5320		

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S5320	Continued From page 40 the only medication with a specific administration time). Interview on 03/03/2020 at 1:47 PM with CMA B revealed she was directed the resident have a liberalized medication pass times with a range for example in the morning can give between 7 am and 9 am and the noon would be 11 am to 1 pm for the hour before and the hour after the scheduled time. Interview on 03/03/2020 at 1530 PM with licensed nurse/operator A revealed he planned for the residents to have a liberalized medication pass time of AM, noon, PM and HS. - Record review on 03/03/2020 at 12:30 PM for resident #411 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). She lacked the ability to manage her own medications. The negotiated service agreement (NSA) dated 02/10/2020 included services of staff assist with ADLs; staff provide 3 meals a day and routine housekeeping/laundry services. Staff were to administer the resident medications. The undated resident care plan directed staff to administer the resident's medications.	S5320		

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S5320	Continued From page 41 Review of the March 2020 medication administration record revealed medication administration times of AM (morning), noon, PM (evening) and HS (bedtime). She had levothyroxine scheduled for 6:00 AM as the only medication with a specific time. Observation on 03/02/2020 at 2:11 PM revealed certified medication aide (CMA) B administering medications. She reported they were the noon medications. On 03/03/2020 at 1:15 PM observation revealed CMA B administering medications which she said were the noon medications. Interview on 03/03/2020 at 1:47 PM with CMA B revealed she was directed the resident have a liberalized medication pass times with a range for example in the morning can give between 7 am and 9 am and the noon would be 11 am to 1 pm for the hour before and the hour after the scheduled time. Interview on 03/03/2020 at 1530 PM with licensed nurse/operator A revealed he planned for the residents to have a liberalized medication pass time of AM, noon, PM and HS. He reported an expectation for the noon medications to be given at noon. The operator failed to ensure the residents' clinical record included the date and a 12-hour or 12-hour clock time for any medication administered to 3 of 3 sampled residents (#309, #326 and #411).	S5320		
S5335 SS=E	28-39-437 Construction	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 _____	03/04/2020

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
S5335	Continued From page 42 (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 resident. Licensed nurse/operator A identified 3 of the 4 residents with cognitive impairment and independently mobile. 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 unlocked chemicals and an unlocked door to the basement stairs. Findings included: - On 03/02/2020 during the initial tour of the facility at 2:46 PM revealed a door adjacent to the front door opened freely and lead to the basement with stairs immediately upon opening. The door had a dead bolt lock mechanism in place which was not activated. Licensed nurse/operator A at that time confirmed the door to the basement should be locked at all times. On 03/02/2020 at 2:51 PM revealed in the resident common bathroom on the counter sat a box with resident #309's personal items easily	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S5335	Continued From page 43 accessible. The box included Polident denture tablets and a tub of Vaseline labeled keep out of reach of children (KORC) and seek medical attention if swallowed and a can of shaving cream on the counter by the 2nd sink labeled KORC. The unlocked cabinet under the 1st sink had an opened bottle of Rejuvenate all floor cleaner which had a warning label to seek medical attention if ingested. The unlocked cabinet under the 2nd sink had an open bucket without a lid of quikrete and a bucket of tile grout. Interview on 03/02/2020 at 2:51 PM with licensed nurse/operator A confirmed the above items should be locked/secured to prevent the cognitively impaired and mobile residents from having access to them. The operator failed to ensure the facility was equipped and maintained to protect the health and safety of residents, personnel and the public regarding unlocked chemicals and an unlocked door to the basement stairs.	S5335		