STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B070004	A. BUILDING: _____ B. WING _____	01/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUBLE RANCH	509 WESTERN HEIGHTS OVERBROOK, KS 66524

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S 000	INITIAL COMMENTS The following citations represent the findings of a an initial survey for the above named Home Plus facility completed on 1-27,28-2020.	S 000		
S5085 SS=E	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c)(2) The facility reported a census of 8 residents. The sample included 3 residents. Based on observation, interview and record review the administrator failed to ensure designated staff conducted a functional screening to determine 2 (#127 and #128) of 3's functional capacity following a significant change in condition as defined in KAR 26-39-100. Findings included: - Review of resident #127's medical record revealed an admission date of 7-24-2019 with diagnoses of dementia, hypertension, osteoarthritis in right knee, and low back pain. Review of the functional capacity screen dated	S5085		

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

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S5085	Continued From page 1 7-23-2019 revealed the resident required supervision with transfers, supervision with walking/mobility and did not identify the resident used a wheelchair. Observation on 1-27-2020 at 3:00 PM certified staff B and licensed nursing staff D assisted the resident to the restroom. Staff pushed the resident into the restroom in his wheelchair and then after staff D put a gait belt on the resident staff lifted the resident to attempt to transfer him onto the toilet. On the 4th attempt staff were finally able to provide enough physical assistance to get him to stand enough to help him turn and sit on the toilet. When the resident was finished staff again had to provide extensive assistance to transfer him from the toilet to his wheelchair. Observation on 1-28-2020 at 12:13 PM other residents were getting up for lunch and the resident started to scoot forward in his recliner. The resident had lowered the foot of the chair himself and continued to scoot to the front edge of the chair. Certified staff C went to the resident and got hold of both of his hands and with staff just holding onto his hands he stood up and walked to the dining room table. During an interview on 1-27-2020 at 2:15 PM certified staff B reported staff needed to basically help the resident do everything. Staff B stated for transfers the resident needed 2 staff for assistance and that he really didn't use his walker anymore and didn't walk anymore. During an interview on 1-28-2019 at 6:03 AM certified staff E reported the resident slept most of the night but if he wanted to get up she would call the other building for someone to come and assist her with transferring him.	S5085		

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S5085	Continued From page 2 - Review of resident #128's medical record revealed the resident admitted to the facility on 7-8-2019 with diagnoses of Alzheimer's disease, and major depressive disorder. Review of the resident's functional capacity screen dated 7-8-2019 revealed the resident required supervision with dressing, toileting, transfers, and walking/mobility. Observation on 1-28-2020 at 8:26 am certified staff C took the resident by the hand and helped him up out of the recliner and then held the residents hand and walked with the other hand on his back to the dining room table. the resident had an unsteady gait and would lean backwards at different times when he walked. Observation on 1-28-2019 at 8:50 AM certified staff C put a gait belt on the resident and assisted him to get out of the dining room chair and walked with the resident to the front room to sit in a recliner all while holding onto the gait belt . During an interview on 1-27-2020 at 2:16 PM certified staff B stated staff needed to help the resident with most activities of daily living. Staff B stated the resident walked but did not have good balance and staff needed to help him with that and transfers for balance. During an interview on 1-28-2020 at 10:41 AM reported that for both resident #127 and #128 the functional capacity would have changed and should have been completed with the residents significant change in status. The dministrator failed to ensure designated staff conducted a functional screening to determine 1	S5085		

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S5085	Continued From page 3 of 3 resident's functional capacity following a significant change in condition as defined in KAR 26-39-100.	S5085		
S5313 SS=F	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 8 residents. The sample included 3. Based on observation and interview, administrative staff A failed to ensure all over the counter medications were labeled with the resident's full name. Findings included: - Observation on 1-27-2020 at 10:41 AM certified staff B opened the medication room door and unlocked the medication cart. Observation revealed the following: in the bottom drawer there was a bottle of Melartonin 5 mg with a residents	S5313		

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S5313	Continued From page 4 last name on it - a box of Systane eye drops without a name on it. In another drawer was a bottle of Vitamin D3 50 mcg, Aspirin 81 mg, 2 bottles of Systane eye drops and a bottle of Melatonin 3 mg tablets that only contained a resident's last name. Facility policy for "Medication Management" revealed over-the-counter medication would be delivered to the facility in it's original, unbroken package. A pharmacist or licensed nurse will place the full name of the resident on the package. lacked procedures for management of over the counter medications. Administrative staff A failed to ensure all over-the-counter medications were labeled with the resident's full name.	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.	S5315		

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S5315	Continued From page 5 (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) The facility reported a census of 8 residents. Based on observation and interviews the administrator failed to ensure licensed nurses or medication aides were the only ones to have access to the stored medications and biologicals in a locked medication cabinet. This failure had the potential to affect all residents. Findings included: - During an interview on 1-27-2020 at 12:12 PM licensed nursing staff D reported the keys for the medication room and the cart which included keys to the narcotic box were kept in and unlocked drawer in the kitchen over night. Staff D stated the certified nurse aide that worked night shift would have access to the keys . The administrator failed to ensure all medications	S5315		

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S5315	Continued From page 6 and biologicals were stored in locked cabinet and licensed nurses or medications aides were the only ones to have access to them.	S5315		