Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087210	A. BUILDING: _____ B. WING _____	R 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD SENIORS, LLC	1226 S BYRON ROAD WICHITA, KS 67209

(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 #20-11 conducted on 1/29/2020 and 1/30/2020.	{S 000}		
{S5035} SS=F	26-42-101 (i) Administration Reports (i) Reports. Each administrator or operator shall ensure the accurate completion and electronic submission of annual and semiannual statistical reports regarding residents, employees, and home occupancy to the department no later than 20 days following the last day of the period being reported. The administrator or operator shall ensure the submission of any other reports required by the department. This REQUIREMENT is not met as evidenced by: KAR 26-42-101 (i) The facility reported a census of 3 residents with all 3 included in the sample. Based on record review and interview the operator failed to complete and electroniclly submit the annual and semiannual statistical reports as mandated in the correction order #20-11 regarding residents, employees and home occupancy to the state department no later than 20 days following the last day of the period being reported. Findings included: - At the time of entrance on 1/29/2020 at 10:30 AM according to the state agency the operator had not submitted a statistical report in the past 2 years. Interview on 1/29/2020 at 11:15 AM licensed	{S5035}		

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

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{S5035}	Continued From page 1 nurse/operator B confirmed she failed to submit the required statistical report as order in the correction order #20-11.	{S5035}		
{S5300} SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d) The facility reported a census of 3 residents. The sample included 3 residents and all 3 received facility management of their medications. Based on observation, record review and interview the operator/licensed nurse B failed to ensure 3 of 3 sampled residents (#1282, #1311 and #1367) received medications and biologicals in accordance with a medical care provider's written order and according to professional standards of	{S5300}		

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{S5300}	Continued From page 2 practice. Findings included: - Record review on 01/29/2020 at 11:45 AM for resident #1282 revealed she admitted to facility on 08/03/17 with diagnoses of Alzheimer's disease, vascular dementia, partial complex seizures, and depression. The functional capacity screen (FCS) dated 07/25/19 failed to identify the resident's cognitive status. The FCS indicated she could not perform management of her medications. Negotiated service agreement (NSA) dated 01/18/2020 included services of a licensed nurse/certified medication aide (CMA) to administer medications and treatments. The record included 2 amendments to the NSA - 01/15/2020 to start home health for physical therapy and 01/25/2020 to stop home health services. The health service plan dated 07/25/2019 directed staff to administer the resident's medications. Review of a recapitulation of a medical care provider's written orders signed 01/20/2020 (not marked as noted by a nurse) and all orders written therafter, when compared to the January 2020 medication administration record (MAR) revealed the following discrepancies: The signed recapitulation of a medical care provider's orders dated 01/20/2020 included acetaminophen 500 milligrams (mg) 1 tablet twice a day by mouth and calmoseptine apply after peri-care. Neither of these 2 orders appear on the January 2020 MAR and the record lacked any	{S5300}		

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{S5300}	Continued From page 3 orders to discontinue these medications. The recapitulation dated 01/20/2020 included an order for Mylanta double strength 400 mg-400mg-40mg/5ml with directions to take 400 mg by mouth as needed for indigestion, per label instructions. On 01/29/2020 at 12:20 PM licensed nurse/operator B retrieved a bottle of regular strength Geri-lanta antacid and antigas liquid with a pharmacy label to take as directed. The pharmacy label covered the manufacture's label but review of the website revealed the bottle had aluminum hydroxide 200 mg in 5 ml with magnesium hydroxide 200 mg in 5 ml and dimethicone 20 mg in 5 ml. The January 2020 MAR included Geri-Lanta liquid (not double strength as ordered) and directed staff to give 30 ml by mouth PRN for indigestion. *note* The 30 ml directions equaled 3 times the prescribed amount. The January 2020 MAR included initials of licensed nurse/operator B on 01/06/2020 to indicate she administered the medication. On the backside of the MAR licensed nurse/operator B recorded she administered 30 cc (cubic centimeters) equilvalent to 30 mls. The January 2020 MAR included the following medications which were not included in the reacapitulation signed 01/20/2020 or and subsequent orders: acidophilus take 1 caplet by mouth every day diphenhydamine 25 mg 1 by mouth 3 times a day PRN rash/itching/allergies mometasone furoate 0.1% apply a few drops to affeacted area daily PRN rash triamcinolone 0.1% cream apply to affected area 2-3 times daily PRN rash soothe PM nightime eye ointment to right eye lid margin at bedtime meloxicam 0.18%/topiramate 1%/tramadol 0.25%/lidocaine 2%/prilocane 2% use as	{S5300}		

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{S5300}	Continued From page 4 directed. Licensed nurse/operator B reported this was a medication the medical care provider would inject and not adminisered by facility staff. Interview on 01/29/2020 at 12:30 PM with licensed nurse/operator B revealed she failed to compare the signed recapitulation of orders dated 01/20/2020 to the January 2020 MAR to verify accuracy and get clarification for discrepancies. She also confirmed the standard of nursing practice included a comparision, clarification if needed and signing the order as noted to indicate the orders were transcribed and accurately reflect the medical care provider's written orders. - Record review on 01/29/2020 for resident #1311 revealed she admitted to the facility on 05/17/17 with diagnoses of urinary tract infection, Parkinson's disease, depression, muscle weakness, dementia without behavioral disturbances, and cirrhosis of liver. The functional capacity screen (FCS) dated 05/15/19 identified the resident with short-term memory deficit and impaired decision making. She lacked the ability to manage her medications and treatments. The negotiated service agreement (NSA) dated 05/15/19 included licensed nurse/certified medication aide (CMA) were to administer medications and treatments. The NSA had amendments dated -7/25/2019 for start of home health services, 09/28/2019 about a diet change and staff monitoring the resident's blood sugar with nurse administration of Trulicity injection and 01/15/2020 which indicated home health services ended on 09/04/2019.	{S5300}		

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{S5300}	Continued From page 5 The health service plan dated 05/17/2019 directed facility staff to adminsiter the resident's medications and treatments. Review of the January 2020 medication administration record (MAR) and compared to a recapitulation of orders signed by a medical care provider on 09/01/2019 and all written orders therafter revealed the following discreapancies: The orders signed 9/01/2019 included an order for Lisinopril 2.5 millgrams (mg) 1 tablet by mouth daily for hypertension, Lidocaine 5% topically patch to bilateral knees PRN (as needed) for neuropathic pain and Aspercreme 4% patch to areas of pain PRN. The January 2020 MAR did not include the 3 orders. The record lacked medical care provider's orders to discontinue any of the 3 medications. A signed telephone order dated 10/04/2019 by a medical care provider directed to increase the resident's cyclobenzaprine from 5 mg at bedtime PRN to 5 mg routinely at bedtime and PRN twice a day. The January 2020 MAR included the routine order of cyclobenzaprine 5 mg at bedtime but the PRN directions were for 1 tablet by mouth every 24 hours as needed for muscle spasms. *note* this discrepancies was cited with the last resurvey on 01/16/2020. The January 2020 MAR indicated licensed nurse/operator B administered the PRN cyclobenzaprine 1 time on 01/07/2020 and 1 time on 01/15/2020. A telephone order dated 11/02/2019 directed for the resident to start receiving calcium 600 mg with vitamin D 200 iu (international units) twice a day with meals. The January 2020 MAR did not include this medication and the resident's record lacked any orders to discontinue the medication. The January 2020 MAR included an entry for cyclobenzaprine 5 mg tablet 1 by mouth at	{S5300}		

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{S5300}	Continued From page 6 bedtime for muscle spasms. The MAR included staff's intials on 01/01/2020 and 01/02/2020 but no other days in January 2020. Observation on 01/29/2020 at 2:30 PM revealed licensed nurse/operator B removed the PRN card for the cyclobenzaprine 5 mg tablets which included directions to administer 1 tablet by mouth every 24 hours as needed for muscle spasms. The card for the routine bedtime dose last dispensed from the pharmacy on 01/22/2020 with the dose bubble empty on 01/22, 23, 24, 25, 26, 27 and 28/2020. Interview on 01/29/2020 at 2:15 PM with licensed nurse/operator B revealed she directed the pharmacy which prints the MARs to remove the lidocaine patch and the aspercreme patch due to resident refusal. She confirmed she failed to get an order to discontinue the medications. She reported the lisinopril was marked as discontinued on the November 2019 MAR as of 11/02/2019 and the record lacked a written order to discontinue. She said the calcium with vitamin D was also discontinued due to insurance would not pay for it but again she did not have a medical care providers written order to discontinue the ordered medication. She confirmed the previously cited discrepancy for the cyclobenzaprine 5 mg twice a day PRN failed to be corrected. She reported the resident received the prescribed routine cyclobenzaprine 5mg at bedtime and confirmed the standard of practice included intialling each medication when administered. - Record review on 01/29/2020 at 12:45 PM for resident #1367 revealed she admitted to the facility on 11/01/19 with diagnoses of	{S5300}		

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{S5300}	Continued From page 7 hypertension, chronic kidney disease stage 4, insomnia, neurogenic bladder, chronic pain, and osteoarthritis. The functional capacity screen (FCS) dated 11/01/19 identified the resident with short-term memory deficit and impaired decision making. She lacked the ability to manage her medications and treatments. The negotiated service agreement (NSA) dated 11/01/19 included a licensed nurse/certified medication aide (CMA) was to administer the resident's medications and treatments. The health service plan dated 11/01/2019 directed staff to administer the resident's medications. Review of the last recapitulation of the medical care provider's orders signed 11/01/2019 and all orders thereafter, when compared to the January 2020 medication adminsitration record (MAR) revealed the following discrepancies: The 11/01/2019 orders include an order for duloxetine 20 milligrams (mg), take 1 capsule by mouth at bedtime for depression. The January 2020 MAR lacked this medication and the record lacked any orders to discontinue the medication. A telephone order dated 11/02/2019 included an order to discontinue vitamin C 500 mg daily. The January 2020 MAR included vitaminc C 500 mg daily and every day staff recorded administration of the medication by means of initials. Interview on 01/29/2020 with licensed nurse/operator B confirmed she failed to discontinue the vitamin C 500 mg as ordered and confirmed the record lacked an order to discontinue the duloxetine.	{S5300}		

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{S5300}	Continued From page 8 For 3 of 3 sampled residents, operator/ licensed nurse B failed to ensure the residents received medications and biologicals in accordance with a medical care provider's written order and according to professional standards of practice.	{S5300}		
{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	{S5315}		

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{S5315}	Continued From page 9 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)(4) The facility reported a census of 3 residents. The resident roster identified the facility managed medications for all residents. Based on observation, record review, and interview the operator failed to ensure medications were not administered beyond the manufacturer's or pharmacy provider's recommended date of expiration for 2 of 3 sampled residents (#1282, and #1311). Findings included: - During the initial tour on 01/29/2020 at 10:45 AM, operator/licensed nurse B opened the only medication cart. Observation revealed the following expired medications remained accessible to staff for administration: Resident #1311 - Ibuprofen 800 milligrams (mg) with 9 tablets in the package. The medication card had a pharmacy label which indicated the pharmacy dispensed the medication on 08/08/2018 and listed an expiration date of 08/08/2019. A medication card of antidiarrheal 2 mg tablets with 16 tablets in the card. The pharmacy label included a dispensing date of 01/05/2019 and an expiration date of 01/05/2020. A medication card of ondansetron hydrochloride 4 mg tablets with 1 tab in the card. The pharmacy label included a dispensing date of 01/23/2019	{S5315}		

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{S5315}	Continued From page 10 and an expiration date of 01/05/2020. Resident #1282 - ondansetron hydrochloride 8 mg tablets with 13 tablets in the card. The pharmacy label included a dispensing date of 03/21/2018 and an expiration date of 02/19/2019. Tylenol (acetaminophen) 500 mg tablets with 17 tablets in the card. The label included dispensing date of 05/30/2018 and expiration date of 05/30/2019. Two cards of antidiarrheal medication with 2 tablets in each dosing bubble. The card of 32 tablets had a label with a dispensing date of 05/16/2018 and expiration date of 05/16/2019. The second card with 18 tablets had a label with a dispensing date of 05/07/2018 and expiration date of 05/07/2019. Three cards of Buspirone hydrochloride 15 mg tablets with 30 tablets on each card and all labels indicated the pharmacy dispensed the medication on 08/11/2017 with an expiration date of 08/11/2018. Interview on 01/29/2020 at 10:55 AM with licensed nurse/operator B confirmed she failed to check each medication in the medication cart following the last resurvey and as mandated by correction order #20-11 to ensure all expired medications were removed and not accessible for administration. She called the pharmacy who dispensed the medication for the facility and confirmed all medications are recommended to expire 1 year after the dispensing date. The operator failed to ensure medications were not administered beyond the manufacturer's or pharmacy provider's recommended date of expiration.	{S5315}		