STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040006	A. BUILDING: _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR PO BOX 5000 HESSTON, KS 67062

(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 licensure resurvey for the above named assisted living facility conducted on 7/23/19, 7/24/19 and 7/25/19.	S 000		
S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility 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 26-41-202 (a) The facility reported a census of 34 residents. The sample included 3 residents and 1 focused review. Based on observation, interview and record review the administrator/operator failed to ensure the written negotiated service agreement for 1 of 4 resident's (#699) included a description of the services the resident would receive with	S3085		

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

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S3085	Continued From page 1	S3085		

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

Findings included:

- Record review for resident #699 revealed an admission date of 12/28/17 with diagnoses of hypertension, hyperthyroidism, mixed hyperlipidemia and dry eye syndrome.

The admission functional capacity screen (FCS) dated 12/28/17 and the annual FCS dated 12/28/18 identified the resident with cognitive impairment of short and/or long-term memory deficit, impaired memory recall and decision making. The resident required physical assistance with medication and treatment management.

The negotiated service agreement (NSA) dated 12/28/18 identified facility staff would administer the resident's medications and medications were obtained from a local named pharmacy. The NSA did not include any information about the resident's use of sample/drug study medications provided by an outside resource provider and the party responsible for payment of the services.

The plan of care dated 12/28/17 indicated facility staff would provide medication management with no information regarding the use of sample/drug study medications.

Review of the resident's paper medical record and the electronic medical record revealed a medical care provider's written order dated 7/09/19 which read Research multivitamin and Cocoa extract by mouth daily - ok for resident to take medication for Research study.

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S3085	Continued From page 2 The record included a Partners Health Care System Research Consent Form dated 5/03/16 signed by the resident. The record also included a 4-page document with contact information for the outcome study, a list of the active ingredients and suitability for dietary preference and allergies. The July 2019 medication administration record (MAR) included the research multivitamin and cocoa extract with daily initials from certified staff which indicated the administration of the drug study medications/supplements. Interview on 7/24/19 at 2:15 PM with licensed nurse B confirmed the NSA failed to identify the drug study medication provided by an outside source, the provider of the service and the party responsible for payment of the outside services. The administrator/operator failed to ensure the written negotiated service agreement for this resident included a description of the services the resident would receive with identification of the provider for each service and the party responsible for payment if outside resources provide a service.	S3085		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility 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	S3200		

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S3200	Continued From page 3	S3200		

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 facility has responsibility.
(2) Medication aides shall not administer medication through the parenteral route.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-205 (d) (A)

The facility reported a census of 34 residents. The sample included 3 residents and 1 focused review. Based on observation, interview and record review the administrator/operator failed to ensure licensed nurses and certified medication aides administered facility managed medications in accordance with a medical care provider's written order and professional standards of practice for 2 of 4 sampled residents #712 and #767.

Findings included:

- Record review for resident #767 revealed an admission date of 1/16/19 with diagnoses of hypertension, major depressive disorder, pain, low back pain, muscle weakness and difficulty walking.

The significant change functional capacity screen dated 6/18/19 identified the resident with impaired decision making but with intact short/long-term memory and memory recall. He/she needed physical assistance with medication/treatment

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management.

The negotiated service plan dated 6/18/19 indicated facility staff would administer all the resident's medications.

The plan of care dated 1/16/19 identified medication management would be provided by facility staff.

Review of the medical care provider's written orders revealed an order for Xanax 0.25 milligrams (mg) by mouth 1 time a day PRN (as needed) with a start date of 1/16/19.

Review of the July 2019 medication administration record revealed the resident received the Xanax PRN 6 times.

During the entrance conference on 7/23/19 at 10:35 AM licensed nurse B reported certified medication aide (CMA)s administered the resident's oral medications.

Observation on 7/23/19 at 12:14 PM revealed licensed nurse B and CMA A entered the medication room. Licensed nurse B used his/her keys to open a double locked cabinet which included controlled substance medications. He/she obtained the cassette box of Xanax 0.25 mg tablets for the resident. CMA A opened the notebook which included the counting/accountability for the controlled substance and recorded the removal of the medication. Licensed nurse B removed the plastic tab over the opening for the tablet and emptied 1 tablet of Xanax 0.25 mg into a clear plastic medication cup. CMA A at no time held the container of the Xanax but took the plastic medication cup which nurse B had placed the

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tablet in and transferred the tablet to another clear plastic medication cup which he/she had written the resident's name on. Then CMA A left the medication room to administer the resident the medication.

Interview on 7/23/19 at 11:53 AM with certified medication aide A revealed only the nurses had the key to the locked cabinet of controlled substances. He/she said the nurse would open the cabinet, remove the medication and give the medication to the CMA to administer to the resident then both sign the medication count book.

Interview on 7/23/19 at 12:20 PM with licensed nurse B confirmed the procedure for removal of controlled substances involved the nurse removing the medication from the locked cabinet and removing the medication from the medication cassette to confirm the correct medication/dose and count.

The facility's policy for administration of medications dated 10/20/00 directed staff that only the licensed nurse or certified medication aide who prepared the medication may give the medication.

The administrator/operator failed to ensure licensed nurses and certified medication aides administered facility managed medications in accordance with a medical care provider's written order and professional standards of practice for this resident regarding administration by the same individual who prepared the medication.

- Record review for resident #712 revealed an admission date of 7/10/19 with diagnoses of hypertension, cognitive impairment, osteoarthritis

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and an abdominal wall abscess.

The admission functional capacity screen dated 7/10/19 identified the resident with memory recall deficit and required physical assistance with medication management.

The negotiated service agreement dated 7/10/19 indicated facility staff would administer the resident's medications.

The plan of care dated 7/10/19 included facility staff to manage the resident's medications.

Review of the medical care provider's signed orders dated 7/09/19 and compared to the July 2019 medication administration record (MAR) revealed a discrepancy regarding an order for Zofran 4 milligrams by mouth every 6 hours PRN (as needed) for nausea. The July 2019 MAR did not include this order.

Interview on 7/24/19 at 10:17 AM with licensed nurse D revealed if the order is showing as active on the electronic medical care provider tab then it should be on the MAR.

On 7/24/19 at 11:00 AM licensed nurse B had reviewed the discrepancy the surveyor identified and explained the error occurred during transcription by not checking the place on the order which will send it to the MAR. He/she confirmed the nurse noting the orders dated 7/09/19 should have compared the orders to the printed MAR for accuracy.

The administrator/operator failed to ensure licensed nurses and certified medication aides administered facility managed medications in accordance with a medical care provider's written

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S3200	Continued From page 7 order and professional standards of practice for this resident.	S3200		
S3214 SS=E	26-41-205 (g) (4) Sample & Indigent Medication Program Meds (g) (4) Licensed nurses and medication aides may administer sample medications and medications from indigent medication programs if the administrator or operator ensures the development of policies and implementation of procedures for receiving and identifying sample medications and medications from indigent medication programs that include all of the following conditions: (A) The medication is not a controlled medication. (B) A medical care provider ' s written order accompanies the medication, stating the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration. (C) A licensed nurse or medication aide receives the medication in its original, unbroken manufacturer ' s package. (D) A licensed nurse documents receipt of the medication by entering the resident ' s name and the medication name, strength, and quantity into a log. (E) A licensed nurse places identification information on the medication or package containing the medication that includes the medical care provider ' s name; the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider ' s order. Facility staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches	S3214		

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S3214	Continued From page 8 the information on the medical care provider ' s order. (F) A licensed nurse informs the resident or the resident ' s legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies. The resident ' s clinical record shall contain documentation that the resident or the resident ' s legal representative has received the information and accepted the risk of potential adverse consequences. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g) (4) (B) (D) (E) (F) The facility reported a census of 34 residents. The sample included 3 residents and 1 focused review. Based on observation, interview and record review the administrator/operator failed to ensure licensed nurses and certified medication aides administered sample medications (drug study medications) per facility policy for 1 of 4 sampled residents (#699) which included a medical care provider's written order accompanying the medication with the resident's name, the medication name, strength, dosage, route and frequency of administration with any cautionary instructions regarding administration. The facility further failed to ensure the licensed nurse documented receipt of the medication by entering the resident's name, the medication name, strength and quantity into a log; placed identification information on the medication or package with the medical care provider's name,	S3214		

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the resident's name, the medication name, strength, dosage, route and frequency of administration with any cautionary instructions as documented on the medical care provider's order; and informed the resident or the resident's legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which required the identification of both adverse drug interactions or reactions and potential allergies with documentation of such in the resident's clinical record.

Findings included:

- Record review for resident #699 revealed an admission date of 12/28/17 with diagnoses of hypertension, hyperthyroidism, mixed hyperlipidemia and dry eye syndrome.

The admission functional capacity screen (FCS) dated 12/28/17 and the annual FCS dated 12/28/18 identified the resident with cognitive impairment of short and/or long-term memory deficit, impaired memory recall and decision making. The resident required physical assistance with medication and treatment management.

The negotiated service agreement (NSA) dated 12/28/18 identified facility staff would administer the resident's medications and medications were obtained from a local named pharmacy. The NSA failed to include information about the resident's use of sample/drug study medications, including identification of the outside provider who provided the drug study medications and identification of each party responsible for payment of the medications.

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S3214	Continued From page 10 The plan of care dated 12/28/17 indicated facility staff would provide medication management with no information regarding the use of sample/drug study medications. Review of the resident's paper medical record and the electronic medical record revealed a medical care provider's written order dated 7/09/19 which read Research multivitamin and Cocoa extract by mouth daily - ok for resident to take medication for Research study. The record included a Partners Health Care System Research Consent Form dated 5/03/16 signed by the resident. The record also included a 4-page document with contact information for the outcome study, a list of the active ingredients and suitability for dietary preference and allergies. The July 2019 medication administration record (MAR) included the research multivitamin and cocoa extract with daily initials from certified staff which indicated the administration of the drug study medications/supplements. On 7/23/19 at 11:53 AM certified medication aide A reported the resident's medications were stored in the resident's room and the medication room contained the extra medication supplies and medications for PRN (as needed) use. Observation of the medication room revealed in the cabinet above the sink were 4 bubble pack packages of drug study medications which had the resident's name written on them. The cards themselves indicated it contained a Cocoa supplement and multivitamin from an outcome study by a research group affiliated with Harvard University.	S3214		

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S3214	Continued From page 11 Interview on 7/23/19 at 1:00 PM with licensed nurse B confirmed the resident received the drug study medications/supplements since his/her admission and previously took the drug study medications/supplements at home. He/she confirmed the drug study medications/supplements come from the drug study group and not a pharmacy. He/she indicated the medical care provider ordered the use of the drug study medications but he/she did not have the drug study medications labeled as required, he/she failed to have a log to reflect receipt of the drug study medications and no documentation of informing the resident or responsible party regarding the potential risks of the drug study medications not going through the usual pharmacy process. Review of the facility policy dated 5/20/11 listed procedures for the use of samples and medications from indigent programs which included a requirement for the following: A medical care provider's written order accompanied the medications stating the resident's name, the medication name, strength, dosage, route and frequency of the administration and any cautionary instructions regarding the administration. The licensed nurse documents the receipt of the medications by entering the resident's name and medication name, strength and quantity into a log. A licensed nurse should place identification information on the medication or package containing the medication which included the medical care provider's name, the resident's name, the medication name, strength, dosage, route and frequency of administration with any cautionary instructions as document on the medical care provider's order.	S3214		

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S3214	Continued From page 12 A licensed nurse informed the resident or the resident's legal representative that the medication did not go through the usual process of labeling and review by the licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto which required the identification of both adverse drug reactions or potential allergies. The resident's clinical record should contain documentation that the resident or the resident's legal representative had received the information of the risks of potential adverse consequences. The administrator/operator failed to ensure licensed nurses and certified medication aides administered sample/drug study medications for this resident in accordance with the facility policy and state regulations regarding a complete medical care provider's written order, licensed nurse labeling of the sample/drug study medications, licensed nurse maintaining a log for receipt of the drug study medications and evidence of informing the resident or resident's representative of the drug study medication not going through the usual pharmacy process and potential adverse consequence in using the drug study medications.	S3214		
S3265 SS=F	26-41-104 (a) Disaster and Emergency Preparedness (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location.	S3265		

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S3265	Continued From page 13 This REQUIREMENT is not met as evidenced by: KAR 26-41-104 (a) The facility reported a census of 34 residents. The facility reported 4 of the 34 residents had cognitive impairment. Based on record review and interview the administrator/operator failed to conduct an emergency evacuation drill with the least amount of staff on duty to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. Findings included: - On 7/23/19 licensed nurse B provided the resident roster which identified 4 residents with cognitive impairment. He/she reported staffing the facility with 1 certified staff member in the evening and overnight. On 7/24/19 at 1:00 PM licensed nurse B provided documentation for the annual evacuation of the facility. The documents included an evacuation on 7/03/19 and 4/10/19. The document dated 7/03/19 and titled, "Monthly fire drill report" indicated the time of the drill was 6:16 AM and marked as an actual fire with a smoke detector on the healthcare side sounding on the 500 hall. The document indicated the residents were evacuated from the 500, 600, 700 and 100 hall as well as the assisted living facility. The scenario included during the monthly generator testing the 500 hall basement generator overheated, began smoking which set off the smoke detector and activating the fire panel. The assisted living residents were evacuated to the outside. The total time for	S3265		

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S3265	Continued From page 14	S3265		

evacuation was recorded as 10 minutes. The report did not indicate how many and which staff participated with evacuating the assisted living residents and only had a copy of the scheduled staff for the day (healthcare and assisted living nursing staff). The document did not reflect how the residents evacuate (ambulatory, by wheelchair and if assisted by staff) and if a staff member stayed with the cognitively impaired residents during the evacuation to ensure those residents remained in a safe area.

Interview on 7/24/19 at 2:05 PM certified staff C present at the time of the 7/03/19 actual evacuation revealed he/she had assistance with the evacuation by housekeeping staff on duty that morning.

Monthly fire drill report dated 4/10/19 with a time of 9:57 AM indicated a complete evacuation of the assisted living facility took place. The comments indicated staff assisted resident down stairs, performed 1 blanket transfer down stairs with an evacuation time of 6 minutes. The documentation did not identify specifically how many staff performed the actual evacuation and listed 19 staff on the signature portion.

The 7/27/18 Monthly fire drill report indicated the evacuation occurred at 12:28 PM, took 5 minutes and included the signature of 4 staff members.

Interview on 7/24/19 at 2:05 PM with administrator/operator E and licensed nurse B confirmed the documents lacked evidence to show the facility had sufficient staff to assist the resident to evacuate in an emergency or disaster to a secure location, lacked how the residents evacuated (ambulatory, by wheelchair and if assisted by staff) and if a staff member stayed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040006	A. BUILDING: _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR PO BOX 5000 HESSTON, KS 67062

(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
S3265	Continued From page 15 with the cognitively impaired residents during the practice evacuation The administrator/operator failed to conduct an emergency evacuation drill with the least amount of staff on duty to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location.	S3265		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (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 facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' 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 26-41-104 (d) (3) The facility reported a census of 34 residents. Based on interview and record review the	S3280		

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S3280	Continued From page 16	S3280		

administrator/operator failed to ensure staff had disaster and emergency preparedness by a failure to conduct a quarterly review of the facility's emergency management plan.

Findings included:

- On 7/23/19 at 4:00 PM the surveyor requested the documentation for training/review of the facility's emergency management plan with residents and staff conducted every quarter since the last survey conducted on 7/17/17.

On 7/24/19 at 12:40 PM licensed nurse B provided a signature page dated 4/12/19 for the residents' review of the facility's emergency management plan and no documentation for a review by the staff.

Interview with certified staff C on 7/24/19 at 1:20 PM revealed he/she knew the location of the emergency operations plan notebook but indicated he/she had not received a review of the entire plan yet this year.

Interview with licensed nurse D on 7/24/19 at 1:20 PM revealed he/she was not aware of the location for the emergency operations plan notebook, or about the emergency plan summary sheet and he/she confirmed a lack of any review of the emergency operations plan yet this year.

Interview with licensed nurse B and administrator/operator E on 7/24/19 at 2:05 PM indicated staff received a partial review (fire drill type, evacuation, emergency communications) during the Monthly fire drill conducted on 4/10/19. Administrator/operator E confirmed the documentation did not reflect a full review of the entire emergency disaster management plan on a

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S3280	Continued From page 17 quarterly basis. The administrator/operator failed to ensure staff had disaster and emergency preparedness by a failure to provide information for a quarterly review on the facility's emergency management plan.	S3280		