STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY STREET AUGUSTA, KS 67010

(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 an abbreviated survey for investigation of complaint #139654 of the above assisted living facility on 5/6/19, 5/7/19, 5/8/19, and 5/9/19.	S 000		
S 195 SS=D	26-39-102 (f) Discharge Notice (f) The administrator or operator, or the designee, shall provide a notice of transfer or discharge in writing to the resident or resident ' s legal representative at least 30 days before the resident is transferred or discharged involuntarily, unless one of the following conditions is met: (1) The safety of other individuals in the adult care home would be endangered. (2) The resident's urgent medical needs require an immediate transfer to another health care facility. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(f) The facility reported a census of 26 residents. The sample included 2 residents and 2 closed records reviewed. Based on record review and interview for 1 (#2) of 2 residents sampled, the operator failed to provide a notice of transfer in writing to the resident's legal representative at least 30 days before the resident was transferred. Findings included: - Record review for resident #2 revealed an admission date of 9/10/14 to the assisted living area of the facility with diagnoses of muscle	S 195		

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

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S 195	Continued From page 1	S 195		

weakness, peripheral vascular disease, and macular degeneration.

Functional capacity screen dated 9/20/18 documented resident was independent with dressing, toileting, transferring, and walking; required supervision for bathing and eating; was unable to perform management of medications and treatments; was continent of urine; experienced impaired short-term memory and memory recall; and was at risk for falls.

Significant change functional capacity screen dated 4/17/19 indicated resident required supervision when eating; physical assistance with bathing, dressing, toileting, transferring, mobility in wheelchair, and management of medications and treatments; experienced impaired short-term memory, memory recall, and decision making; and was at risk for falls. The functional capacity screen indicated resident received hospice services.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 4/17/19 documented services of bathing assistance provided by hospice aide; facility certified staff provided physical assistance with dressing, toileting, transferring, mobility in wheelchair; supervision when eating; redirection and reorientation to address impaired cognition; and interventions to address risk for falls of high-low bed, floor mat beside bed, and hourly visual check. NSA/HCSP documented the name of a hospice provider.

Nurse's notes contained an entry by licensed nurse C on 4/3/19 at 9:21 p.m. regarding incident date of 4/2/19 that resident was observed laying on his/her back with head underneath bed. Certified staff member moved bed to be able to

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S 195	Continued From page 2 speak to resident. Resident alert. Certified staff member stated resident was pale and blood pressure lower than normal. Resident unable to recall or voice what he/she was attempting to do. resident stated he/she was looking "for the dead people, they are everywhere." Durable power of attorney contacted and agreed resident could be transferred to hospital emergency department for evaluation. Emergency department personnel reported CT (computed tomography) scan and x-rays negative and no lab work completed. Emergency department reported resident's bladder was drained of 1 liter of urine. Notified resident's medical care provider and received order for lab work and urinalysis. Contacted durable power of attorney and requested for resident to be moved to memory care due to "reporting (he/she) is seeing dead people in boxes with 'drugs.' Alert, delusional, and increase confusion." Resident moved to memory care with belongings, durable power of attorney updated. During an interview at 1:26 p.m. on 5/7/19, licensed nurse C stated resident was moved to the memory care unit due to multiple falls and increased confusion. Licensed nurse C stated the durable power of attorney was not provided with a written 30-day notice of need to transfer resident from assisted living to a memory care facility due to "it was more of an urgent move." Licensed nurse C stated he/she and operator B made the decision to move resident from his/her assisted living apartment to a room in the memory care unit. The operator failed to provide a notice of transfer in writing to resident #2's legal representative at least 30 days before the resident was transferred.	S 195		

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S3028	Continued From page 3	S3028		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(c) The facility reported a census of 26 residents. The sample included 2 residents and 2 closed	S3028		

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S3028	Continued From page 4	S3028		

records reviewed. Based on record review and interview for 2 (#1 and #2) of 2 residents sampled and 2 (#4 and #3) of 2 closed records reviewed, the operator failed to ensure each potential allegation of abuse or neglect was reported to the department within 24 hours of the incident and failed to thoroughly investigate each incident to rule out staff abuse or neglect of each resident.

Findings included:

- Closed record review for resident #4 revealed an admission date of 11/15/18 with diagnoses of dementia, major depressive disorder, and psychotic disorder.

Functional capacity screen (FCS) dated 1/28/18 indicated resident required supervision with mobility; physical assistance with bathing, dressing, toileting, and transferring; was at risk for falls; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and resident's communication was usually understood, and resident sometimes understood verbal communication.

FCS dated 3/20/19 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and mobility with walker or wheelchair; was at risk for falls; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and resident's communication was sometimes understood, and resident sometimes understood verbal communication.

Resident's record contained the following addendums to the negotiated service agreement/health care service plan (NSA/HCSP)

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S3028	Continued From page 5	S3028		

dated 1/28/18 after resident experienced a fall:

3/5/19 Medical care provider to review medications. Order for physical and occupational therapy.

3/14/19 Orders for lab work.

3/17/19 Obtain orthostatic blood pressure reading for 3 days.

NSA/HCSP dated 3/21/19 documented staff to assist resident with transferring, toileting, dressing, and mobility with walker or wheelchair due to weakness and fatigue; hospice aide to assist with bathing; and fall interventions of encourage resident to sit in commons area with staff present, hourly visual checks, and activities of knitting and coloring. The record contained an addendum to the NSA dated 3/23/19 due to fall staff to check oxygen saturation every shift and apply oxygen as needed if restless.

Nurse's notes contained the following entries:

3/7/19 at 8:16 a.m. licensed nurse E documented that at 7:15 a.m., staff notified nurse resident on floor in his/her room. Sitting on floor incontinent of bowel. Resident complained of pain in coccyx and buttocks when walking. No documentation to explain how resident came to be on floor.

3/12/19 at 8:32 p.m. licensed nurse C documented certified staff F called to report resident on floor in living room around 10:30 a.m. Resident attempted to stand from wheelchair and sat on floor. Resident complained of pain with movement to left hip. X-ray of left hip ordered. Negative for fracture. Entry did not document if fall was witnessed.

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S3028	Continued From page 6 3/12/19 at 8:38 p.m. licensed nurse C documented certified staff G reported resident observed sitting on floor in living room around 10:00 p.m. Family member visiting another resident reported resident attempted to stand and transfer self. 3/14/19 at 3:49 p.m. licensed nurse C documented certified staff F reported at 8:45 a.m. resident on floor at doorway to bathroom. Resident had removed brief and was incontinent of bowel. 3/15/19 at 2:10 p.m. licensed nurse C documented resident had an unwitnessed fall in living room. Resident stated he/she did not know what happened. 3/15/19 at 2:23 p.m. licensed nurse C documented resident had an unwitnessed fall around 7:00 p.m. on 3/12/19 in the living room. Resident reported pain with movement of leg and resident began rubbing hip. Medical care provider order obtained for resident to be transported by ambulance to hospital for evaluation. Resident returned to facility. 3/24/19 at 12:12 a.m. licensed nurse C documented he/she received a call from certified staff G at 5:10 p.m. on 3/23/19 resident observed laying on floor next to bed in room. Intervention for resident to have mat on floor by bed. The entry did not document if resident explained how he/she came to be on floor. 3/24/19 at 12:25 a.m. licensed nurse C documented notified by certified staff G on 3/23/19 at 5:45 p.m. resident leaning forward in wheelchair at supper and fell to floor. Certified	S3028		

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S3028	Continued From page 7	S3028		

staff G observed resident hit left side of forehead on floor. Resident's durable power of attorney refused evaluation at hospital. Oxygen saturation 76% on room air. Oxygen applied at 2 liters per minute with oxygen saturation at 96%. Intervention: check oxygen saturation when restless and apply oxygen for comfort due to history of hypoxia.

3/25/19 at 8:52 p.m. licensed nurse E documented that at 7:00 p.m. on 3/17/19, staff notified this nurse that they were assisting another resident when they heard "help" coming from the commons area. Staff responded to the area and found resident lying on left side on the floor. Resident complained of pain to buttocks. Range of motion within normal limits for resident. Resident stated, "I fell." Resident was last observed by staff at 6:58 p.m. sitting in wheelchair in commons area.

4/3/19 at 10:36 p.m. licensed nurse C documented certified staff H reported resident lying on back in dining room at 2:20 p.m. Hematoma noted to back of head, alert, and moaning in pain. Hospice and durable power of attorney declined to send resident to hospital emergency department.

At 4:00 p.m. on 5/7/19, licensed nurse C stated the falls were not reported to the department. Licensed nurse C provided the investigations of the incidents. Review of the investigations revealed no conclusion reached and no documentation if abuse/neglect substantiated or unsubstantiated.

The operator failed to ensure each potential allegation of abuse or neglect was reported to the department within 24 hours of the incident and

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S3028	Continued From page 8 failed to thoroughly investigate each incident to rule out staff abuse or neglect of resident #4. - Record review for resident #2 revealed an admission date of 9/10/14 with diagnoses of muscle weakness, peripheral vascular disease, and macular degeneration. Hospice began services for resident on 4/3/19 and added diagnosis of senile degeneration of brain. Functional capacity screen dated 9/20/18 documented resident was independent with dressing, toileting, transferring, and walking; required supervision for bathing; experienced impaired short-term memory and memory recall; and was at risk for falls. Significant change functional capacity screen dated 4/17/19 indicated resident required physical assistance with bathing, dressing, toileting, transferring, mobility in wheelchair; experienced impaired short-term memory, memory recall, and decision making; and was at risk for falls. Negotiated service agreement/health care service plan dated 4/17/19 documented services of bathing assistance provided by hospice aide; facility certified staff provided physical assistance with dressing, toileting, transferring, mobility in wheelchair; redirection and reorientation to address impaired cognition; and interventions to address risk for falls of high-low bed, floor mat beside bed, and hourly visual check. The record contained the following addendums to the negotiated service agreement: 4/18/19 Fall intervention to toilet every night between 2:00 a.m. and 4:00 a.m. or as needed when restless.	S3028		

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4/23/19 due to fall 4/23/19 staff educated to toilet resident at 2:00 a.m. every night and any time resident noted to be restless at night.

Nurse's notes contained the following entries:

4/3/19 at 9:21 p.m. licensed nurse C documented that on 4/2/19 staff observed resident laying on his/her back with head underneath bed. Certified staff member moved bed to be able to speak to resident. Resident alert. Certified staff member stated resident was pale and blood pressure lower than normal. Resident unable to recall or voice what he/she was attempting to do. resident stated he/she was looking "for the dead people, they are everywhere." Durable power of attorney contacted and agreed resident could be transferred to hospital emergency department for evaluation.

4/3/19 at 9:56 p.m. licensed nurse C documented certified staff members heard a loud noise followed by (resident) yelling "help." Staff members found resident laying on left side with active bleeding to left side of eyebrow. Staff member instructed by nurse to apply pressure with an ice pack to eye but unable to slow bleeding. Resident transported by ambulance to hospital emergency room for treatment and returned with 4 sutures above left eyebrow.

4/11/19 at 3:47 a.m. licensed nurse C documented certified staff J notified nurse at 3:15 a.m. resident observed sitting on floor in doorway to bathroom. Resident unable to recall if fell from wheelchair or when walking with wheelchair to bathroom. Intervention: offer assistance to bathroom during night between 2:00 a.m. and 4:00 a.m. and as needed for restlessness.

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S3028	Continued From page 10 4/23/19 at 8:55 a.m. licensed nurse K documented he/she was notified at 2:15 a.m. resident was found on the floor in his/her room lying beside bed at 2:13 a.m. after staff heard a loud noise. Resident stated he/she fell when walking back to bed from the bathroom and did hit head. Resident transported to hospital emergency room for evaluation. Resident returned to facility with no new orders. "Staff have been educated to assist resident to the bathroom every night at 2:00 a.m. and any time (resident) is noted to be restless at night." During an interview at 1:26 p.m. on 5/7/19, licensed nurse stated these incidents were not reported to the department. At 3:30 p.m. on 5/7/19 surveyor reviewed "Occurrence Reports" provided by licensed nurse C as the investigations of incidents. The reports did not draw a conclusion or rule out abuse/neglect. Licensed nurse D stated the licensed nurse completing the Occurrence Report was responsible for documenting the conclusion and if abuse/neglect determined. The operator failed to ensure each potential allegation of abuse or neglect was reported to the department within 24 hours of the incident and failed to thoroughly investigate each incident to rule out staff abuse or neglect of resident #2. - Closed record review for resident #3 revealed an admission date of 2/12/19 with diagnoses of dementia and chronic ischemic heart disease. Functional capacity screen dated 2/12/19 indicated resident required physical assistance with bathing, dressing, toileting, and transferring;	S3028		

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supervision with ambulation; required use of a walker or wheelchair; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and was at risk for falls.

Negotiated service agreement/health care service plan dated 2/12/19 documented staff to provide physical assistance with bathing, dressing, toileting, stand-by assistance with ambulation with walker; and high fall risk, keep walkway clear and well lit. The record contained a negotiated service agreement addendum dated 3/16/19 to add restorative toileting program due to weakness and an addendum dated 3/18/19 of resident had a fall, sent to emergency room for evaluation.

Nurse's notes contained the following entries:

3/26/19 at 10:29 p.m. by licensed nurse C that resident returned from hospital stay after a stroke affecting right side. Hospital reported resident was a high risk for falls and restless. Licensed nurse C documented resident returned to facility at 2:30 p.m. with hospice nurse present. At 3:15 p.m. licensed nurse C received a call that resident had slid out of bed after hospice nurse left the room.

4/3/19 at 10:15 p.m. by licensed nurse C that around 7:35 p.m. staff observed resident laying on his/her back attempting to roll onto right side in front of wheelchair. Certified staff H stated resident slid out of wheelchair.

During an interview at 1:45 p.m. on 5/7/19, licensed nurse C stated the incidents on 3/26/19 and 4/3/19 were not reported to the department.

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Review of the occurrence reports revealed the lack of thorough investigations to rule out abuse and/or neglect.

The operator failed to ensure each potential allegation of abuse or neglect was reported to the department within 24 hours of the incident and failed to thoroughly investigate each incident to rule out staff abuse or neglect of resident #3.

- Record review for resident #1 revealed an admission date of 5/14/18 with diagnoses of dementia and hypertension.

Functional capacity screen dated 3/29/19 indicated resident was independent with dressing, toileting, transferring, and walking with walker; experienced impaired short-term memory, long-term memory, memory recall, and decision making; exhibited wandering behavior; and was not at risk for falls.

Negotiated service agreement/health care service plan dated 3/29/19 documented resident was at risk for falls and had a call light to summon help when needed. The record contained an addendum to the negotiated service agreement dated 5/3/19 that documented obtain urinalysis due to fall.

Nurse's notes contained an entry by licensed nurse C at 11:41 p.m. on 5/2/19 that certified staff L called to report resident was found sitting on floor in dining room with pants pulled down to above knees. Certified staff L reported he/she attempted to toilet resident prior to finding resident ton floor but resident became agitated.

At 1:48 p.m. on 5/7/19, licensed nurse C stated the incident on 5/2/19 was not reported to the

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S3028	Continued From page 13 department. Review of the occurrence report for the incident 5/2/19 revealed the lack of a thorough investigation to rule out abuse and/or neglect. The operator failed to ensure a potential allegation of abuse or neglect was reported to the department within 24 hours of the incident and failed to thoroughly investigate the incident to rule out staff abuse or neglect of resident #1.	S3028		
S3130 SS=D	26-41-203 (d) Special Care Services (d) Special care. Any administrator or operator of an assisted living facility or residential health care facility may choose to serve residents who do not exceed the facility ' s admission and retention criteria and who have special needs in a special care section of the facility or the entire facility, if the administrator or operator ensures that all of the following conditions are met: (1) Written policies and procedures are developed and are implemented for the operation of the special care section or facility. (2) Admission and discharge criteria are in effect that identify the diagnosis, behavior, or specific clinical needs of the residents to be served. The medical diagnosis, medical care provider ' s progress notes, or both shall justify admission to the special care section or the facility. (3) A written order from a medical care provider is obtained for admission. (4) The functional capacity screening indicates that the resident would benefit from the services and programs offered by the special care section or facility. (5) Before the resident ' s admission to the	S3130		

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	N008008	A. BUILDING: _____ B. WING _____	05/09/2019

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S3130	Continued From page 14 special care section or facility, the resident or resident's legal representative is informed, in writing, of the available services and programs that are specific to the needs of the resident. (6) Direct care staff are present in the special care section or facility at all times. (7) Before assignment to the special care section or facility, each staff member is provided with a training program related to specific needs of the residents to be served, and evidence of completion of the training is maintained in the employee's personnel records. (8) Living, dining, activity, and recreational areas are provided within the special care section, except when residents are able to access living, dining, activity, and recreational areas in another section of the facility. (9) The control of exits in the special care section is the least restrictive possible for the residents in that section. This REQUIREMENT is not met as evidenced by: KAR 26-41-203(d)(1)(2)(3)(4)(5) The facility reported a census of 26 residents. The sample included 2 residents and 2 closed records reviewed. Based on record review and interview for 1 (#2) of 2 residents sampled, the operator transferred the resident from the assisted living facility to the memory care unit and failed to ensure written policies and procedures were developed and implemented for the operation of the memory care unit; admission criteria were in effect that identified the diagnosis, behavior, or specific clinical needs of the resident to be served; that the medical diagnosis, medical	S3130		

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S3130	Continued From page 15	S3130		

care provider's progress notes, or both justified admission to the memory care unit; a written order from a medical care provider was obtained for the transfer; the functional capacity screening indicated that the resident would benefit from the services and programs offered by the memory care unit; and before the resident's transfer to the memory care unit, the resident's legal representative was informed, in writing, of the available services and programs that were specific to the needs of the resident.

Findings included:

- Record review for resident #2 revealed an admission date of 9/10/14 to the assisted living area of the facility with diagnoses of muscle weakness, peripheral vascular disease, and macular degeneration.

Functional capacity screen dated 9/20/18 documented resident was independent with dressing, toileting, transferring, and walking; required supervision for bathing and eating; was unable to perform management of medications and treatments; was continent of urine; experienced impaired short-term memory and memory recall; and was at risk for falls.

Significant change functional capacity screen dated 4/17/19 indicated resident required supervision when eating; physical assistance with bathing, dressing, toileting, transferring, mobility in wheelchair, and management of medications and treatments; experienced impaired short-term memory, memory recall, and decision making; and was at risk for falls. The functional capacity screen indicated resident received hospice services.

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S3130	Continued From page 16 Negotiated service agreement/health care service plan (NSA/HCSP) dated 4/17/19 documented services of bathing assistance provided by hospice aide; facility certified staff provided physical assistance with dressing, toileting, transferring, mobility in wheelchair; supervision when eating; redirection and reorientation to address impaired cognition; and interventions to address risk for falls of high-low bed, floor mat beside bed, and hourly visual check. NSA/HCSP documented the name of a hospice provider. Nurse's notes contained an entry by licensed nurse C on 4/3/19 at 9:21 p.m. regarding incident date of 4/2/19 that resident was observed laying on his/her back with head underneath bed. Certified staff member moved bed to be able to speak to resident. Resident alert. Certified staff member stated resident was pale and blood pressure lower than normal. Resident unable to recall or voice what he/she was attempting to do. resident stated he/she was looking "for the dead people, they are everywhere." Durable power of attorney contacted and agreed resident could be transferred to hospital emergency department for evaluation. Emergency department personnel reported CT (computed tomography) scan and x-rays negative and no lab work completed. Emergency department reported resident's bladder was drained of 1 liter of urine. Notified resident's medical care provider and received order for lab work and urinalysis. Contacted durable power of attorney and requested for resident to be moved to memory care due to "reporting (he/she) is seeing dead people in boxes with 'drugs.' Alert, delusional, and increase confusion." Resident moved to memory care with belongings, durable power of attorney updated.	S3130		

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S3130	Continued From page 17	S3130		

Resident's record lacked a medical care provider's written order to transfer resident to the memory care unit. The record lacked documentation by a medical care provider that resident would benefit from residing in the memory care unit. Resident was admitted to hospice for service with a hospice diagnosis of senile degeneration of brain on 4/3/19. The resident's active (9/20/18) functional capacity screen at the time of transfer to memory care unit on 4/2/19 did not indicate resident would benefit from the transfer. A significant change functional capacity screen and negotiated service agreement/health care service plan was not developed until 4/17/19.

During an interview at 1:26 p.m. on 5/7/19, licensed nurse C stated resident was moved to the memory care unit due to multiple falls and increased confusion. Licensed nurse C stated he/she and operator B made the decision to move resident from his/her assisted living apartment to a room in the memory care unit. Licensed nurse C reviewed the electronic medical record and could not find a written and signed medical care provider's order to transfer the resident to the memory care unit. Licensed nurse C stated the order likely had not been scanned yet. Licensed nurse C stated he/she did not conduct a functional capacity screen or develop a negotiated service agreement/health care service plan until 4/17/19 because he/she wanted to see how resident "was going to do in the next day or two...looked like resident was going to pass." Licensed nurse C did not know where to find or if there were policies and procedures for the operation of the memory care unit.

At 4:55 p.m. on 5/7/19, licensed nurse D provided a printed document from the resident's electronic

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S3130	Continued From page 18 medical record to admit resident to memory care unit which did not include the medical care provider's signature. Licensed nurse D stated he/she could not locate policies and procedures for the operation of the memory care unit on his/her computer. The operator transferred resident #2 from the assisted living facility to the memory care unit and failed to ensure written policies and procedures were developed and implemented for the operation of the memory care unit; admission criteria were in effect that identified the diagnosis, behavior, or specific clinical needs of the resident to be served; that the medical diagnosis, medical care provider's progress notes, or both justified admission to the memory care unit; a written order from a medical care provider was obtained for the transfer; the functional capacity screening indicated that the resident would benefit from the services and programs offered by the memory care unit; and before the resident's transfer to the memory care unit, the resident's legal representative was informed, in writing, of the available services and programs that were specific to the needs of the resident.	S3130		
S3200 SS=D	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 recommendations. The administrator or operator	S3200		

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S3200	Continued From page 19 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) The facility reported a census of 26 residents. The sample included 2 residents and 2 closed records reviewed. Based on record review and interview for 1 (#4) of 2 closed records reviewed, the operator failed to ensure the resident received a medication as ordered and according to standards of practice. Findings included: - Record review for resident #4 revealed an admission date of 11/15/18 with diagnoses of dementia, major depressive disorder, and psychotic disorder. Functional capacity screen dated 3/20/19 indicated resident required physical assistance with management of medications. Negotiated service agreement/health care service plan dated 3/21/19 documented certified medication aide (CMA) and licensed nurses would administer medications as directed by physician.	S3200		

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S3200	Continued From page 20	S3200		

The record contained a medical care provider's written order dated 4/1/19 for Ceftriaxone (antibiotic) 1 gram with Lidocaine (local anesthetic) intramuscular (IM) injection daily for 3 days to treat urinary tract infection.

Review of the April 2019 medication administration record (MAR) revealed resident received a dose of the medications on 4/3/19 and 4/4/19 as indicated by initials on those dates. The MAR did not document that resident received a dose on any other date as the third dose.

Nurse's notes contained the following entries by licensed nurse C:

4/1/19 of new order received from medical care provider for Rocephin (Ceftriaxone) IM for 3 days due to urinalysis positive for bacteria. Licensed nurse C documented the nurse was to administer and injection scheduled to start tomorrow.

4/3/19 at 12:20 p.m. licensed nurse C documented he/she contacted hospice related to Rocephin IM injection and when hospice nurse would be available to give injection. Licensed nurse C documented he/she informed the hospice nurse the Rocephin injection was not given yesterday as ordered by the hospice medical care provider.

During an interview at 1:36 p.m. on 5/7/19, licensed nurse stated resident did not receive the first Rocephin injection on 4/2/19 as ordered. Licensed nurse C stated the hospice nurse did not come to administer the injection on 4/2/19 but did come on 4/3/19 to administer the injection. Licensed nurse C stated he/she administered the injection on 4/4/19 and 4/5/19. Licensed nurse C reviewed the Rocephin entry on the April 2019

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S3200	Continued From page 21 MAR and stated the initials on 4/3/19 and 4/4/19 were those of a CMA. Licensed nurse C stated he/she instructed the CMA to initial the MAR after the nurse administered the Rocephin. The licensed nurse that administered each injection did not document this on the resident's MAR. The operator failed to ensure resident #4 received a medication as ordered and according to standards of practice.	S3200		