

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 02/11/2019
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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 are the result of a Revisit and Correction Order #19-7 at the above named Assisted Living Facility in Leawood, Kansas on 02/05/19, 02/06/19, 02/07/19, and 02/11/19.	{S 000}		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The census equalled 15 the sample included four Residents. The Resident Roster identified two Residents who self administered medications, not included in the sample. Based on observation, interview, and reviews of record, for one of four sampled who self-administered medication (#1075), the Operator failed to ensure a licensed	S3175		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3175	Continued From page 1 nurse performed an assessment and determined the Resident could perform the function safely and accurately without staff assistance, and failed to ensure the assessment completed at least annually. Findings included: - Review of record revealed #1075 admitted to facility 12/16/13 with diagnoses of major depression, gastroesophageal reflux disease, chronic pain, hypertension, allergic rhinitis, osteoporosis, venous thrombosis, dosalgia, and weakness. The 9/27/18 FCS (functional capacity screen) assessed #1075 unable to perform medication and treatment management. The 9/27/18 NSA/HSP (negotiated service agreement/health service plan) documented facility staff to maintain, control, and administer all of #1075's medications, and treatments. The NSA/HSP lacked mention of any self administration of medication or treatments. The medical record contained a physician's order dated 01/02/19 for Preparation H ointment 0.25% apply QID (four times daily) PRN (as needed). On 02/06/19 at 2:30pm in Resident's room, with Regional RN (registered nurse) #I, observed tube of Preparation H (hemorrhoidal ointment) in bathroom... #1075 confirmed the need for the ointment and confirmed self administration of the ointment. The NSA/HSP lacked a description of self administration of medication. The medical record contained a self administration assessment dated 01/09/18 with the notation: "the only medications #1075 self	S3175			

STATE FORM

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{S3200}	Continued From page 3 The census equalled 15 the sample included four Residents. The Resident roster identified two Residents who self administered medications, not included in the sample. Based on observations, interviews, and reviews of records, for four of four sampled (#1077, #1089, #1081, and #1075), the Operator failed to ensure all medications and biological's administered to Residents in accordance with a medical care provider's written orders and in accordance with professional standards of practice. Findings included: - Review of facility medication cart and medication storage room with certified medication aide (CMA) #T; review of individual sampled Resident in room medication storage cabinets; and comparison of these reviews with written physician's orders in Residents' records revealed discrepancies. - Review of record revealed #1089 admitted 7/16/18 with diagnoses of weakness, failure to thrive, edema, overactive bladder, gastroesophageal reflux disease, major depressive disorder, falls, chronic obstructive pulmonary disease, diabetes, and hypertension. The 01/08/19 FCS (functional capacity screen) assessed #1089 in need of physical assistance with medication and treatment management. The 01/08/19 NSA/HSP (negotiated service agreement/health service plan) documented #1089 to receive medication and treatment management. Comparison of the medical record, the current January and February 2019 MAR's (medication	{S3200}			

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{S3200}	Continued From page 4 administration records, and items in medication storage, the following discrepancies noted: Bottle of Tums (antacid) tablets in Resident room storage "opened 01/01/19", with 66 tablets remaining of the original 72; the MAR and the medical record lacked a current order for Tums. Box of Mucinex (guaifenesin, an expectorant) 1200mg (milligrams) not open; Box of Mucinex DM (guaifenesin 1200mg and dextromethorphan [cough suppressant] 60mg) not open; Box of Mucinex D (guaifenesin 600mg and pseudoephedrine [a decongestant that shrinks blood vessels in the nasal passages] 60mg open with four tablets missing. Review of the medical record revealed the following orders: 01/02/19 - Robitussin (guaifenesin) 100mg/5ml (milliliters) give 10ml every four hours PRN (as needed) 10/23/18 - Mucinex 600mg by mouth BID (twice daily) for seven days 7/27/18 - Mucinex 600mg by mouth BID for five days The stored medications and the MAR's failed to match the written physician orders. Review indicated Mucinex with pseudoephedrine added administered in place of plain guaifenesin as ordered, in the amount ordered. A box of ipratropium-albuterol vials with label directing four times daily; review of physician's written order revealed "01/02/19 increase Duoneb [ipratropium-albuterol] to QID (four times daily)"; comparison of the MAR revealed this medication not administered according to physician's orders; Three times not four times per day on 01/04/19, 01/06/19, 01/12/19, 01/13/19, 01/14/19, 01/31/19, 02/04/19 (no explanation documented); Two times not four times per day on 01/12/19; One time not four times per day on 01/09/19;	{S3200}		

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{S3200}	Continued From page 5 In addition, MAR revealed documentation of multiple doses administered at the same clock time: 02/01/19 two doses administered at 10:08am (for 6am and 10am); 01/27/19 two doses administered at 9:54am (for 10am and 6am); 01/26/19 two doses documented at 9:21am (for 10am and 6am); 01/24/19 two doses documented at 9:41am (for 6am and 10am); 01/15/19 two doses documented at 9:27am (for 6am and 10am); 01/14/19 two doses documented at 12:43pm (for 10am and 6am); 01/12/19 two doses documented at 3:18pm (for 2pm and 6pm); 01/13/19 three doses documented at 3:18pm (for 10am, 2pm, 6am); 01/11/19 two doses documented at 12:21pm (for 6am and 10am); 01/07/19 two doses documented at 11:00am (for 10am and 6am); 01/02/19 two doses documented at 7:59pm (for 2pm and 6pm). Bottles of 50+ multi vitamin and OcuVite eye vitamins observed in the storage cabinet, open and in use, and noted to have multi vitamins and eye vitamins in the prepackaged strip envelopes prepared by the pharmacy; One package of meclizine (dizziness) 28 of 30 tablets dated 6/24/18, and an additional supply of 28 of 28 tablets filled on 7/25/18. On 02/06/19 at 5:00pm company resource licensed nurse #Z confirmed above orders and documented administrations failed to demonstrate medications administered as ordered and in accordance with professional standards of practice.	{S3200}			

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{S3200}	Continued From page 6 - Review of record revealed #1081 admitted to facility 10/01/12 with diagnoses of gastroesophageal reflux disease, dementia, muscle weakness, urine retention, anxiety, hypertension, depressive disorder, edema, dysphagia, and mood disorder. The 9/28/18 FCS (functional capacity screen) assessed #1081 unable to perform medication and treatment management. The 9/28/18 NSA/HSP (negotiated service agreement/health service plan) documented #1081 to receive medication and treatment management. Comparison of the medical record, the current January and February 2019 MAR's (medication administration records), and items in medication storage, the following discrepancies noted: Physician's order 01/15/19 Alprazolam (controlled anti-anxiety medication) 0.5mg (milligrams) PRN (as needed) every eight hours. The Controlled Medication Count Sheet logged doses of Alprazolam administered: 01/08/19 at 12:30 01/09/19 at 0900 01/10/19 at 0800 01/11/19 at 1000 01/13/19 at 0700 01/14/19 at 0700 three doses sent with family 01/16/19 at 1300 02/01/19 at 0916. The January and February 2019 MAR's lacked documentation of these doses. The medical record progress notes also lacked documentation of these doses or the need for them or the	{S3200}		

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{S3200}	Continued From page 7 results/effects of the doses given. Physician's order 01/18/19 Prednisone (steroid) 20mg give two tablets (40mg) one time daily for five days. Observed medication punch card in cart with two tablets remaining. Label recorded delivery of 10 tablets (5 doses) on 01/17/19. MAR recorded no dose administered on 01/18/19 'not available.' The medical record lacked licensed nurse clarification or notification of physician that all five ordered doses not administered. This failure to administer medications in accordance with written order, and failure to clarify/notify physician failed to meet professional standards of practice. On 02/06/19 at 5:00pm company resource licensed nurse #Z confirmed above orders and documented administrations failed to demonstrate medications administered as ordered and in accordance with profession standards of practice. - Review of record revealed #1077 admitted to facility 12/29/15 with diagnoses of congestive heart failure, muscle weakness, chronic kidney disease, weakness, hypertension, acute cystitis, dysphagia, and history of falling. The 11/15/18 FCS (functional capacity screen) assessed #1077 in need of physical assistance with medication and treatment management. The 11/15/18 NSA/HSP (negotiated service agreement/health service plan) documented #1077 to receive medication and treatment management.	{S3200}		

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{S3200}	Continued From page 8 Comparison of the medical record, the current January and February 2019 MAR's (medication administration records), and items in medication storage, the following discrepancies noted: Container of Ventolin (albuterol, bronchodilator) inhaler; the medical record and the MAR lacked this order. On 02/06/19 at 5:00pm company resource licensed nurse #Z confirmed the medical record lacked an order for this medication. - Review of record revealed #1075 admitted to facility 12/16/13 with diagnoses of gastroesophageal reflux disease, major depressive disorder, chronic pain, hypertension, allergic rhinitis, weakness, dorsalgia, history of venous thrombosis, and falls. The 9/27/18 FCS (functional capacity screen) assessed #1075 unable to perform medication and treatment management. The 9/27/18 NSA/HSP (negotiated service agreement/health service plan) documented #1075 to receive medication and treatment management. Comparison of the medical record, the current January and February 2019 MAR's (medication administration records), and items in medication storage, the following discrepancies noted: A nearly full bag of Caltrate calcium plus D chocolate chews in storage cabinet (observed expired 02/2018); an order on the January and February 2019 MAR's "Caltrate 600+D Plus Minerals 600mg calcium-800 unit-40mg chew	{S3200}		

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{S3200}	Continued From page 9 tablet (give 600mg) tablet, chewable; observed white calcium tablet in prepackaged pill strips, identified as calcium 600mg and 800 units vitamin D, given to Resident daily with other pre-packaged pills. The medical record lacked documentation of order change, or of licensed nurse clarification of order with physician. On 02/06/19 at 2:45pm, pharmacist confirmed we do not send Caltrate chews in accordance with order on the MAR... we fill prescription with a tablet. (Observed the MAR specified plus minerals, not included in the pill strip package). A bottle of Flonase (allergy nasal spray) in room storage with prescription label "two sprays both nostrils daily;" Physicians order dated 9/16/16 documented "Flonase give one spray intranasal both nostrils one time daily." MAR's documented facility staff administered the Flonase daily. On 02/06/19 at 4:00pm company resource licensed nurse #Z confirmed the medical record order and MAR failed to match the order on the prescription label... confirmed no clarification with physician in the medical record. MAR's contained an 01/02/19 order for "Robitussin Cough-Chest Congestion DM 5mg-100mg/5ml oral liquid (give 10ml) liquid oral PRN (as needed) every four hours." The written physician's order "Robitussin solution 100mg/5ml - take 10ml every four hours PRN for 14 days - cough" Observation of the package revealed: "Robafen 100mg/5ml syrup take 10ml 200mg every 4 hours prn cough for 114 days. The bottle label and the written physician's order failed to match the order documented on the	{S3200}			

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{S3200}	Continued From page 10 MAR. The medical record lacked evidence of licensed nurse clarification of this order. On 02/06/19 at 5:00pm company resource licensed nurse #Z confirmed the medical record lacked clarification of these orders, and failed to demonstrate orders administered in accordance with written orders and in accordance with professional standards of practice. The Operator failed to ensure all medications administered to #1081, #1089, #1075, and #1077 in accordance with written medical care provider orders, and in accordance with professional standards of practice.	{S3200}			
{S3211} SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (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 26-41-205(g)(3)	{S3211}			

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{S3211}	Continued From page 11 The census equalled 15 the sample included four Residents. The Resident Roster identified two Residents who self administered medications, not included in the sample. Based on observation, interview, and reviews of record, for one of four sampled (#1077) and one over the counter medication with no owner identified, the Operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the Resident on each accepted original, unbroken manufacturer's package of over-the-counter (OTC) medication for Resident administration. Findings included: - By observation on 02/06/19 at 11:15am, in review of the Assisted Living medication room and medication cart with CMA (certified medication aide #T, the following noted to lack the first and last name of each Resident: Top drawer of medication cart with opened bottle of Tylenol (analgesic) with no first or last name (CMA stated do not know who the Tylenol belongs to) #1077- Bottle of Leg Cramp supplement, first name, no last name. On 02/06/19 at 11:15am, CMA #T confirmed these items lacked the first and last name. The Operator failed to ensure the licensed nurse or licensed pharmacist placed the first and last names of Resident on each accepted, original, unbroken manufacturer's package of OTC medication for #1077 and all Residents with facility managed medications.	{S3211}		

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{S3215}	Continued From page 12	{S3215}		
{S3215} SS=E	26-41-205 (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 facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility 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 facility. (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 26-41-205(h)	{S3215}		

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{S3215}	Continued From page 13 The census equalled 15 the sample included four Residents. The Resident roster identified two Residents who self administered medications, not included in the sample. For three of four sampled (#1075, #1089, and #1077) and three non sampled (#1068, #1087, and #1083) Residents with facility managed medications, the licensed nurses and medication aides failed to ensure medications not administered beyond the manufacturer's or pharmacy provider's recommended date of expiration. Findings included: - By observation on 02/06/19 from 11:15am to 2:04pm, in the medication cart, in the medication storage room of facility, and in individual medication storage cabinets in Resident rooms, observed the following to be expired or beyond the suggested destruction date: Medication Cart with Certified Medication Aide #T #1068 - Melatonin expired 7/05/18; bottle of Nystatin powder expired 6/22/17 #1087 - tube of Hydrocortisone cream 1% (Resident discharged to another facility) #1083 - bottle of calcium 600+D expired 4/19/18 Individual medication storage cabinets with Regional RN (registered nurse) #I #1075 - Tylenol (analgesic) tablets 325mg (milligrams) expired 01/12/19; nearly full bag of Caltrate 600+D soft chocolate chews expired 02/2018; this cabinet also contained a prescription package of Estrace (estrogen vaginal cream) for another Resident. #1089 - bottle of Pepto Bismal (stomach upset) liquid expired 06/2018 #1077 - bottle of Mintox (Maalox upset stomach)	{S3215}		

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{S3215}	Continued From page 14 expired 11/02/18; bottle of milk of magnesia (laxative) expired 11/02/18; five full bottles and two part bottles of "Leg Cramp" supplement, no expiration dates identified In the course of the these reviews of medication cart and individual room storage cabinets, CMA #T and Regional RN #I confirmed the above medications stored beyond the recommended expiration dates. On 02/06/19 at 5:00pm facility staff provided facility policy for medication management titled "Ordering and Receiving Medications From Provider Pharmacy." This policy and procedure failed to address expiration dates and procedures for medications and biologicals. Licensed nurses and medication aides failed to ensure medications and biologicals not stored and administered beyond the manufacturer's recommended dates of discard.	{S3215}		
{S3216} SS=E	26-41-205 (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 facility 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 destruction of any deteriorated, outdated, or	{S3216}		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 02/11/2019
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
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{S3216}	Continued From page 15 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 26-41-205(i) The census equalled 15 the sample included three Residents. The Resident roster identified two Residents who self administered medications, not included in the sample. Based on observation, interviews and reviews of records, for four of four sampled (#1089, #1081, #1077, and #1077), three non-sampled (#1087, #1068, #1083), and all Residents with medication management, the Licensed nurses and Medication aides failed to maintain records of receipt and disposition of medications in sufficient detail for an accurate reconciliation according to acceptable standards of practice. Findings included: - Observations on 02/06/18 from 11:15am to 5:00pm, in the facility medication cart, the facility medication room, and in individual Resident room medication storage cabinets revealed a lacking method for determining all professional standards of medications maintained. Observations revealed:	{S3216}		

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{S3216}	Continued From page 16 #1089 - Bottle of Tums (antacid) tablets in Resident room storage "opened 01/01/19" with 72 tablets; 66 tablets remaining; the MAR and the medical record lacked an order for Tums; not able to reconcile doses. Box of Mucinex D (guaifenesin 600mg and pseudoephedrine [a decongestant that shrinks blood vessels in the nasal passages] 60mg open with four tablets missing; no current order for this medication; not able to reconcile doses. A box of ipratropium-albuterol vials with label directing four times daily; review of physician's written order revealed "01/02/19 increase Duoneb [ipratropium-albuterol] to QID (four times daily)"; comparison of the MAR revealed this medication not administered according to physician's orders - on some days administered one, two or three times, instead of four; some doses documented as administered together; not able to reconcile doses. Bottles of 50+ multi vitamin and Ocuvite eye vitamins observed in the storage cabinet, open and in use, and noted to have multi vitamins and eye vitamins in the prepackaged strip envelopes prepared by the pharmacy; not able to reconcile doses from bottles. #1081 - Physician's order 01/15/19 Alprazolam (controlled anti-anxiety medication) 0.5mg (milligrams) PRN (as needed) every eight hours. The Controlled Medication Count Sheet logged doses of Alprazolam administered: 01/08/19 at 12:30 01/09/19 at 0900 01/10/19 at 0800 01/11/19 at 1000 01/13/19 at 0700	{S3216}			

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{S3216}	Continued From page 17 01/14/19 at 0700 three doses sent with family 01/16/19 at 1300 02/01/19 at 0916. The January and February 2019 MAR's lacked documentation of these doses. The medical record progress notes also lacked documentation of these doses or the need for them or the results/effects of the doses given. Not able to reconcile doses. #1077 Container of Ventolin (albuterol, bronchodilator) inhaler; the medical record and the MAR lacked this order. Not able to reconcile doses. #1075 A nearly full bag of Caltrate calcium plus D chocolate chews in storage cabinet (observed expired 02/2018); an order on the January and February 2019 MAR's "Caltrate 600+D Plus Minerals 600mg calcium-800 unit-40mg chew tablet (give 600mg) tablet, chewable; observed white calcium tablet in prepackaged pill strips, identified as calcium 600mg and 800 units vitamin D, given to Resident daily with other pre-packaged pills. Not able to reconcile doses, or when form of ordered medication changed. #1068 - Melatonin expired 7/05/18; bottle of Nystatin powder expired 6/22/17 #1087 - tube of Hydrocortisone cream 1% (Resident discharged to another facility no longer here) #1083 - bottle of calcium 600+D expired 4/19/18 On 02/06/19 at 5:00pm facility staff provided facility policy for medication management titled "Ordering and Receiving Medications From	{S3216}		

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{S3216}	Continued From page 18 Provider Pharmacy." This policy and procedure failed to address acquisition, disposition, and reconciliation of medication doses for an accurate accounting of doses. On 02/06/19 at 5:00pm Operator #F, Regional RN (registered nurse) #I, and company resource licensed nurses #Y and #Z confirmed unable to reconcile the doses of medications as described and reviewed above... confirmed we still have some work to do in this area... Licensed nurses and medication aides failed to maintain records of receipt and disposition of medications for #1089, #1081, #1077, #1075, #1068, #1087, #1083, and all Residents with facility managed medications, in sufficient detail for an accurate reconciliation.	{S3216}		