STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B040002	A. BUILDING: _____ B. WING _____	11/13/2018

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RL FOUNTAINWOOD 1	2004 FOUNTAINWOOD STREET HUTCHINSON, KS 67502

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 11/7/18 and 11/13/18.	S 000		
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 12 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to ensure residents who received facility managed medications received medications by a licensed nurses or medication aides in accordance with a medical care provider's written order and professional standards of practice regarding administration of	S5300		

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

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S5300	Continued From page 1 PRN (as needed) medications for 2 of 3 sampled residents (#216 and #293). Findings included: - Record review for resident #216 revealed an admission date of 10/26/16 with diagnoses of chronic pain, Parkinson's, chronic obstructive pulmonary disease, muscle spasms and anxiety. The annual functional capacity screening (FCS) dated 10/26/18 indicated the resident had impaired short/long-term memory, memory recall and decision making. The resident was unable to perform any activities of daily living (ADLs) and medication management. The previous annual FCS dated 10/26/17 revealed the resident had the same cognition, needed physical assistance with bathing, dressing, walking/mobility and unable to perform transfers, toileting, eating and medication management. The negotiated service agreement/health care services (NSA/HCS) dated 10/26/18 indicated the facility managed the resident's medications and medication by gastric tube was delegated to certified medication aides (CMA). He/she was dependent on staff for all ADLs. Review of the physician's orders dated 9/4/18 revealed an order for Lorazepam (a medication to treat anxiety) 0.5 milligrams (mg) 1 tablet by gastric tube every 6 hours as needed for agitation. On 10/8/18 the physician increased the Lorazepam to 1 mg every 6 hours PRN (as needed) agitation per gastric tube. Review of the October 2018 medication administration record (MAR) revealed facility CMAs administered Lorazepam 0.5 mg 9 times.	S5300		

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S5300	Continued From page 2 Review of the portion for documentation of the reason for the administration and effects of the PRN CMAs on 8 of the documented reasons for administration wrote anxiety and 1 time of "yelling, cursing and just out of control". CMAs also documented administration of Lorazepam 1 mg twenty-eight (28) times with 22 times given for anxiety, 5 times for agitation and 1 for "screaming, yelling, cursing out". The MAR documentation did not include a consult with a licensed nurse to assess and determine if the resident needed the medication or other intervention and to ensure the medication was given as prescribed by the physician. On 10/10/18 the MAR recorded an administration of Lorazepam 1 mg at 4:00 PM for anxiety by CMA A and Lorazepam 1 mg at 9:16 PM (5 hours and 15 minutes) for anxiety by CMA F. Neither the MAR or the nursing notes reflected a consult with a nurse or a physician to administer the medication at less than 6 hours as prescribed. On 10/18/18 the MAR recorded administration of Lorazepam 1 mg for anxiety at 6:38 PM by CMA A and of Lorazepam 1 mg for anxiety at 10:20 PM (3 hours and 42 minutes) by CMA F. Neither the MAR or the nursing notes reflected a consult with a nurse to administer the medication at less than 6 hours as prescribed. Review of the November 2018 MAR revealed CMAs administered Lorazepam 1 mg 5 times with the documented reason being anxiety. The MAR documentation did not include a consult with a licensed nurse to assess and determine if the resident needed the medication or other intervention and to ensure the medication was given as prescribed by the physician.	S5300		

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S5300	Continued From page 3 The physician orders dated 9/4/18 included an order for cyclobenzaprine 10 mg 1 tablet by gastric tube daily at bedtime as needed for muscle spasms. Review of the October 2018 MAR revealed CMAs administered cyclobenzaprine 10 mg five (5) times. Three times (10/13/18, 10/14/18 and 10/25/18) CMAs recorded the reason for administration as pain. Neither the MAR or the nursing notes reflected a consult with a nurse regarding giving the medication for pain rather than as prescribed for muscle spasms. Observation on 11/7/18 at 12:15 PM revealed CMA A prepared to administer the resident his/her medications by gastric tube. Interview on 11/07/18 at 4:45 PM with licensed nurse B, licensed nurse G and licensed nurse H revealed staff were directed to call the nurse for all PRN medication needs. The nurses confirmed the record lacked any documentation of the consultation with a nurse on the PRN medication administrations. The operator failed to ensure this resident received medications by a licensed nurses or medication aides in accordance with a medical care provider's written order and professional standards of practice regarding administration of PRN medications certified staff administered PRN medication more frequently than specified in the medical care providers order and when certified staff administered PRN medication requiring nursing assessment and judgement without contacting the nurse. - Record review for resident #293 revealed an admission date of 10/16/18 with diagnoses of	S5300		

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S5300	Continued From page 4	S5300		

hypertension, bilateral lower extremity edema, spinal stenosis, bursitis of right elbow, gouty arthropathy and seizures.

The admission functional capacity screen (FCS) dated 10/10/18 identified the resident with impaired short/long term memory, memory/recall and impaired decision making. He/she needed physical assistance with all activities of daily living (ADLs) and was unable to manage his/her own medications.

The negotiated service agreement/health care services dated 10/10/18 indicated facility staff would administer the resident's medications and provided 1 staff assist with all ADLs.

Review of the physician orders dated 10/16/18 revealed an order for hydrocodone-acetaminophen (a narcotic pain reliever) 1/2 a tablet of 10/325 milligram (mg) tablets every 4-6 hours as needed for pain. The order did not include a specific type or location of pain.

Review of the November 2018 medication administration record (MAR) revealed CMAs administered the hydrocodone/acetaminophen 12 times. The MAR documentation included a reason for the administration 11 out of 12 times as pain (general none specific) and 1 time for anxiety. The MAR documentation did not include a consult with a licensed nurse to assess and determine if the resident needed the medication or other intervention and to ensure the medication was given as prescribed by the physician.

Review of the nursing notes revealed no entries related to the resident's pain, assessment of pain or directions for the CMAs to administer a PRN

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S5300	Continued From page 5 pain medication. Observation on 11/7/18 at 10:40 AM the resident's family member vocalized to licensed nurse G that the resident had turned on the call light for a pain pill. At 10:52 AM CMA D reported to CMA A the resident wanted a pain pill. During direct observation between 10:40 AM until 11:14 am no nurse assessed the resident's report of pain. At 11:14 AM CMA A prepared and administered the resident routine medications and reported putting a 1/2 tab of hydrocodone/acetaminophen in the medications. Interview on 11/07/18 at 4:45 PM with licensed nurse B, licensed nurse G and licensed nurse H revealed staff were directed to call the nurse for all PRN medication needs. Licensed nurse G reported he/she did not hear the resident's request for a pain pill. Licensed nurse H was also not aware the resident was having pain. The operator failed to ensure this resident received medications by a licensed nurses or medication aides in accordance with a medical care provider's written order and professional standards of practice regarding administration of PRN medications when certified staff administered PRN medication requiring nursing assessment and judgement without contacting the nurse.	S5300		
S5302 SS=E	26-42-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and	S5302		

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S5302	Continued From page 6 amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d) (4) The facility reported a census of 12 residents with 2 who received facility management of insulin (a medication to treat elevated blood sugars). Based on record review and interview the operator failed to have evidence of delegation of the preparation of the insulin pen for certified medication aide (CMA) C, D and E to ensure the CMAs were trained and competent to perform the task. Findings included: - On 11/7/18 at 1:00 PM licensed nurse/operator B reported certified medication aides (CMAs) were delegated to perform blood sugar testing and preparation of insulin (a medication to treat elevated blood sugars) pens for residents. Review of the documentation provided for CMA C on 11/07/18 revealed he/she began employment on 4/16/18 and completed a nurse to CMA delegation list signed 4/16/18 which indicated CMA C understood and could fully demonstrate the listed delegations. The listed delegations included obtaining a blood sugar but failed to include preparation of insulin pens for residents to administer. Review of the documentation provided for CMA D on 11/07/18 revealed he/she began employment on 5/08/18 and completed a nurse to CMA delegation list signed 5/08/18 which indicated CMA D understood and could fully demonstrate	S5302		

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S5302	Continued From page 7 the listed delegations. The listed delegations included obtaining a blood sugar but failed to include preparation of insulin pens for residents to administer. Review of the documentation provided for CMA E on 11/07/18 revealed he/she began employment on 10/12/18 and completed a nurse to CMA delegation list signed 10/12/18 which indicated CMA E understood and could fully demonstrate the listed delegations. The listed delegations included obtaining a blood sugar but failed to include preparation of insulin pens for residents to administer. Interview with licensed nurse/operator C on 11/07/18 at 3:45 PM confirmed the facility documentation for CMA C, D and E did not include training/demonstration of competency for insulin pen preparation. He/she provided an undated training opportunity for delegation of preparing insulin pen for resident administration of insulin which CMAs C, D and E signed. This documentation included a step by step procedure guide but did not include evidence the CMAs performed a demonstration of the procedure to ensure safety and competency. The document did not include a signature of a nurse for each CMA to indicate the task delegated to that CMA could be safely/competently provided. For CMA C, D and E, the operator failed to ensure the licensed nurse oriented and instructed the medication aides in the performance of preparation of an insulin pen. The licensed nurse further failed to ensure the medication aide's demonstration of the competency necessary to perform the delegated task was documented in writing and the designated medication aide and licensed nurse co-signed the documentation.	S5302		

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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 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)	S5315		

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S5315	Continued From page 9 The facility reported a census of 12 residents and 2 received insulin (medication for treatment of elevated blood sugar) injections. Based on observation, interview and record review the operator failed to ensure licensed nurses and medication aides could not administer medication beyond the manufacturer's or pharmacy provider's recommended date of expiration for 1 of 2 residents who received outdated insulin over an extended period (#396). Findings included: - On 11/7/18 the facility provided a resident roster which identified 2 resident who received insulin (medication for treatment of elevated blood sugar) injections. Observation on 11/7/18 at 11:50 AM revealed certified medication aide (CMA) A leaving the room of resident #396 going towards the medication cart. In his/her hand was blood sugar testing supplies and an insulin pen for resident #396. CMA A reported he/she had tested the resident's blood sugar, dialed the insulin pen and the resident injected him/herself with the Novolog insulin from the pen. Observation of the Novolog pen revealed the pen had no date when opened and had 12 units left in the syringe of 250 units. CMA A reported the resident received 2 units 3 times a day for a daily total of 6 units. This indicated the resident received insulin from this syringe for approximately 39 days. On 11/7/18 at 11:50 AM CMA A opened the only medication cart. Observation revealed a Lantus insulin pen for resident #396 in the top drawer. The Lantus pen had a date opened of 9/13/18. The resident received insulin from this Lantus	S5315		

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S5315	Continued From page 10	S5315		

pen for approximately 54 days. CMA A reported the unopened pens were kept in the refrigerator and when he/she opened a pen he/she should write the date on the pen. CMA A did not know what the date indicated or how long the insulin could be safely used after opening.

The Novolog Flex pen manufacture recommended to store opened insulin at room temperature for up to 28 days and discard even if insulin remained.

The Lantus Solostar pen manufacture recommended to store opened pens at room temperature and after 28 days the opened Lantus pen should be thrown away-even if it still has insulin in it.

Interview on 11/7/18 at 11:55 AM with licensed nurse B confirmed the Novolog insulin pen without a date and Lantus insulin pen was used past the 28 days for recommended use. He/she reported staff should write the date when opened on the pen. He/she confirmed the CMAs did not have a readily available resource to refer to for the expiration dates on the insulin pens.

The operator failed to ensure licensed nurses and medication aides could not administer medication beyond the manufacturer's or pharmacy provider's recommended date of expiration for resident #396 who received outdated Novolog and Lantus insulin over an extended period.