STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087216	A. BUILDING: _____ B. WING _____	10/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BOOMERS HOME PLUS, LLC	6953 E KENTFORD CIRCLE WICHITA, KS 67226

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with investigation of complaint #134010 of the above home plus facility on 10/8/18, 10/9/18, and 10/10/18.	S 000		
S 110 SS=D	26-39-103 (c) NOTICE OF RIGHTS AND SERVICES (c) Notice of rights and services. (1) Before admission, the administrator or operator shall ensure that each resident or the resident's legal representative is informed, both orally and in writing, of the following in a language the resident or the resident ' s legal representative understands: (A) The rights of the resident; (B) the rules governing resident conduct and responsibility; (C) the current rate for the level of care and services to be provided; and (D) if applicable, any additional fees that will be charged for optional services. (2) The administrator or operator shall ensure that each resident or the resident ' s legal representative is notified in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care. This STANDARD is not met as evidenced by: KAR 26-39-103(c)(2) The facility reported a census of 7 residents. The sample included 3 residents, 1 resident focus reviewed, and 1 closed record reviewed. Based on record review and interview for 1 (#312) of 3	S 110		

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

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S 110	Continued From page 1	S 110		

residents sampled, operator B failed to ensure the resident's legal representative was notified in writing of a room rate increase at least 30 days before the effective date of the rate increase.

Findings included:

- Record review for resident #312 revealed an admission date of 1/10/17 with diagnoses of senile degeneration of brain, Hypertension, atrial fibrillation, and diabetes mellitus type 2.

Functional capacity screen dated 4/29/18 indicated resident required physical assistance with all activities of daily living; was unable to perform management of medications and treatments; was incontinent of urine; 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 4/29/18 documented facility staff to provide physical assistance with bathing, dressing, toileting, ambulation with walker, and administration of medications.

The admission agreement dated 1/10/17 documented the resident's monthly financial responsibility to the facility.

During an interview at 2:52 p.m. on 10/9/18, operator B stated resident room rate was increased 8/1/18 and could not provide proof that resident's legal representative was given a written notice of a room rate increase 30 days prior to the increase. Operator B stated he/she may have verbally informed the resident's legal representative of the rate increase.

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S 110	Continued From page 2 Operator B failed to ensure the legal representative for resident #312 was notified in writing of a room rate increase at least 30 days before the effective date of the rate increase.	S 110		
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 7 residents. The sample included 3 residents, 1 resident focus reviewed, and 1 closed record reviewed. Based on record review, observation, and interview for 2 (#312 and #310) of 3 residents sampled, operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each resident and were in accordance with the functional capacity screening (FCS) and the negotiated service agreement (NSA). Findings included: - Record review for resident #312 revealed an admission date of 1/10/17 with diagnoses of	S5155		

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S5155	Continued From page 3 senile degeneration of brain, hypertension, atrial fibrillation, and diabetes mellitus type 2. FCS dated 4/29/18 indicated resident required physical assistance with bathing, dressing, toileting, transferring, mobility, and eating; was unable to perform management of medications and treatments; was incontinent of urine; experienced impaired short-term memory, long-term memory, memory recall, and decision making; experienced impaired vision; and was at risk for falls. NSA dated 4/29/18 documented facility staff to provide health care services of physical assistance with bathing, dressing, toileting, ambulation with walker, and administration of medications. The NSA did not describe services provided to address resident's need for physical assistance when transferring as specified in the FCS. NSA documented resident "legally blind." Health care service plan dated 4/29/18 did not describe services provided for transfer assistance. Health care service plan documented resident legally blind. During time in the facility on 10/9/18, surveyor observed a hospice home health aide provide physical assistance to resident to transfer from a recliner to a wheelchair. At 12:00 p.m. on 10/9/18 surveyor observed certified medication aide E transfer resident using a gait belt from recliner to wheelchair and mobilized resident to dining room table. Resident sat with eyes closed while certified medication aide E fed lunch to resident. During an interview at 2:10 p.m. on 10/9/18, licensed nurse D confirmed the NSA did not include services for transfer assistance.	S5155		

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S5155	Continued From page 4 Licensed nurse C stated "yes" when asked if resident would require total assistance from a staff member to exit the facility and confirmed the NSA did not address this need. Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #312 and were in accordance with the FCS and the NSA. - Record review for resident #310 revealed an admission date of 5/1/18 with diagnoses of unspecified dementia, cardiac pacemaker, type 2 diabetes mellitus, and essential hypertension. FCS dated 9/25/18 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and walking; was unable to perform management of medications and treatments; was frequently incontinent of urine; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and exhibited wandering and socially inappropriate behaviors. NSA dated 9/25/18 documented services of assistance with bathing, toileting, incontinence care, and dressing; staff to assist with ambulation when experiencing weakness and transferring from low seating; administration of medications and treatments. NSA did not specify provider of assistance with pacemaker monitoring. Nurses notes contained an entry by a licensed nurse dated 8/14/18 that pacemaker was checked and transmission successful. During an interview at 1:53 p.m. on 10/9/18, licensed nurse D stated a licensed nurse	S5155		

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S5155	Continued From page 5 performed pacemaker check for the resident. Licensed nurse confirmed this service was not described in the NSA. Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #310 and were in accordance with the FCS and the NSA.	S5155		
S5161 SS=D	26-42-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(d) The facility reported a census of 7 residents. The sample included 3 residents, 1 resident focus reviewed, and 1 closed record reviewed. Based on record review and interview for 1 (#312) of 3 residents sampled, operator B failed to ensure the negotiated service agreement (NSA) contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. Findings included: - Record review for resident #312 revealed an admission date of 1/10/17 with diagnoses of senile degeneration of brain, Hypertension, atrial fibrillation, and diabetes mellitus type 2.	S5161		

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S5161	Continued From page 6 Functional capacity screen dated 4/29/18 indicated resident required physical assistance with all activities of daily living; was unable to perform management of medications and treatments; was incontinent of urine; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and was at risk for falls. NSA dated 4/29/18 documented facility staff to provide health care services of physical assistance with bathing, dressing, toileting, ambulation with walker, and administration of medications. The NSA contained the name of licensed nurse J as the licensed nurse responsible for the health care service plan. Review of the list of employees hired since 12/1/16 listed licensed nurse J no longer employed by the facility. During an interview at 2:10 p.m. on 10/9/18, licensed nurse D confirmed the resident's NSA needed revision to include the name of the current licensed nurse responsible for the health care service plan. Operator B failed to ensure the NSA for resident #312 contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan.	S5161		
S5195 SS=E	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage,	S5195		

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S5195	Continued From page 7 preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(f) The facility reported a census of 7 residents. The sample included 3 residents, 1 resident focus reviewed, and 1 closed record reviewed. Based on observation and interview for all residents, operator B failed to ensure staff stored food under safe and sanitary conditions. Findings included: - During tour of the facility kitchen at 12:50 p.m. on 10/8/18, surveyor observed the following food items not stored under safe and sanitary conditions: Clear plastic cannister labeled "buttermilk pancake mix." A plastic scoop was stored in the pancake mix. Bottom drawer of refrigerator held a 16-ounce package of raw ground beef and a 16-ounce package of raw ground turkey also stored with a partial plastic bag of shredded cheese and a plastic storage bag of cooked sliced turkey. The facility's food safety policy and procedure only specified raw meats to not be stored with cooked meats. At 2:42 p.m. on 10/8/18, operator B observed the pancake mix cannister with scoop and the raw	S5195		

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S5195	Continued From page 8 meat stored with other food items. Operator B removed the shredded cheese and cooked turkey from the refrigerator, sat the items on the kitchen countertop, and instructed staff to not store raw meat with other food items. For all residents, operator B failed to ensure staff stored food under safe and sanitary conditions.	S5195		
S5258 SS=E	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced by:	S5258		

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S5258	Continued From page 9 KAR 26-42-102(d)(3) The facility reported a census of 7 residents. The sample included 3 residents, 1 resident focus reviewed, and 1 closed record reviewed. Based on record review and interview for 4 of 4 certified medication aide (CMA) employee files reviewed, operator B failed to provide supporting documentation from the Kansas nurse aide registry that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home. Findings included: - Review of employee files with operator B at 3:00 p.m. on 10/9/18 revealed the following: CMA F hired 10/2/18 CMA G hired 8/5/18 CMA H hired 9/28/18 CMA I hired 7/30/18 Each employee's file contained a printed Kansas nurse aide registry confirmation notice that lacked a date as evidence the operator secured this document prior to the employee providing resident care in the facility. Operator B stated and confirmed each form lacked a date. Operator B failed to provide supporting documentation from the Kansas nurse aide registry that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home.	S5258		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the	S5300		

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S5300	Continued From page 10 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 7 residents. The sample included 3 residents, 1 resident focus reviewed, and 1 closed record reviewed. Based on record review, observation, and interview for 1 (#314) of 1 resident focus reviewed, operator B failed to ensure that a medication was administered to the resident in accordance with a medical care provider's written order. Findings included: - Record review for resident #314 revealed an admission date of 7/11/16 with diagnoses of hypertension, dementia, and disorder of urinary system. Functional capacity screen dated 8/6/18 indicated resident was unable to perform management of medications. Negotiated service agreement/health care service plan dated 8/6/18 documented certified medication aides or	S5300		

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S5300	Continued From page 11 licensed nurses administered medications to resident. At 1:16 p.m. on 10/8/18 surveyor observed certified medication aide (CMA) E unlock the medication cart and open a drawer that held a box of Myrbetriq (medication to treat overactive bladder) tablets without a pharmacy label. CMA E stated the medication belonged to (resident #314) and was supplied by the resident's medical care provider. Surveyor observed the medical care provider's writing on the box with resident's name, dosage to be administered, and frequency of administration. The resident's record lacked a written medical care provider's order for administration of the medication. During an interview at 1:36 p.m. on 10/9/18, licensed nurse C and licensed nurse D each unable to find a written medical care provider's order for the medication. Licensed nurse C provided the September 2018 medication administration record that documented resident began receiving the medication once daily on 9/22/18. Operator B failed to ensure that a medication was administered to resident #314 in accordance with a medical care provider's written order.	S5300		
S5314 SS=D	26-42-205 (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	S5314		

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S5314	Continued From page 12 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. Staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches 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	S5314		

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S5314	Continued From page 13 the resident or 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 26-42-205(g)(4)(A)(B)(C)(D)(F) The facility reported a census of 7 residents. The sample included 3 residents, 1 resident focus reviewed, and 1 closed record reviewed. Based on interview, observation, and record review for 1 (#314) of 1 resident receiving a sample medication supplied by the resident's medical care provider, operator B failed to develop a policy and implement procedures for receiving and identifying the sample medication that included the conditions of the medication is not a controlled medication; 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; a licensed nurse or medication aide receives the medication in its original, unbroken manufacturer's package; a licensed nurse documents receipt of the medication by entering the resident's name and the medication name, strength, and quantity into a log; staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches the information on the medical care provider's order; and 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	S5314		

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S5314	Continued From page 14 identification of both adverse drug interactions or reactions and potential allergies; and the resident's clinical record shall contain documentation that the resident or resident ' s legal representative has received the information and accepted the risk of potential adverse consequences. Findings included: - At 1:16 p.m. on 10/8/18 surveyor observed certified medication aide (CMA) E unlock the medication cart and open a drawer that held a box of Myrbetriq (medication to treat overactive bladder) tablets without a pharmacy label. CMA E stated the medication belonged to (resident #314) and was supplied by the resident's medical care provider. Surveyor observed the medical care provider's writing on the box with resident's name, dosage to be administered, and frequency of administration. The facility's "Sample Medication Policy" documented "Sample medication (1) The resident's medical care provider [policy listed medical care providers of doctor, advanced registered nurse practitioner, nurse practitioner, physician's assistant] may give their patient samples of medication at {name of facility]. The sample drug is requiring to be label with the resident's name, practitioner's name, date of dispensed, name and strength of drug and directions for its use (unless these are on the sample package). The policy did not specify that medication could not be a controlled medication; a medical care provider's written order must accompany the medication that stated the resident's name, the	S5314		

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	B087216	A. BUILDING: _____ B. WING _____	10/10/2018

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S5314	Continued From page 15 medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration; a licensed nurse or medication aide received the medication in its original, unbroken manufacturer's package; a licensed nurse documented receipt of the medication by entering the resident's name and the medication name, strength, and quantity into a log; staff consisting of either two licensed nurses or a licensed nurse and a medication aide verified that the information on the medication matched the information on the medical care provider's order; and 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 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; and the resident's clinical record contained documentation that the resident or resident's legal representative received the information and accepted the risk of potential adverse consequences. Record review for resident #314 revealed an admission date of 7/11/16 with diagnoses of hypertension, dementia, and disorder of urinary system. Functional capacity screen dated 8/6/18 indicated resident was unable to perform management of medications. Negotiated service agreement/health care service plan dated 8/6/18 documented certified medication aides or licensed nurses administered medications to resident. The resident's record lacked a written medical care provider's order for administration of the medication. Record also lacked documentation	S5314		

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S5314	Continued From page 16 that the resident and/or legal representative were informed 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; and the resident's clinical record contained documentation that the resident or resident's legal representative received the information and accepted the risk of potential adverse consequences. During an interview at 1:36 p.m. on 10/9/18, licensed nurse C and licensed nurse D each unable to find a written medical care provider's order for the medication. Licensed nurse C provided documentation of the receipt of the medication into the facility that lacked a date. Licensed nurse C provided the September 2018 medication administration record that documented resident began receiving the medication once daily on 9/22/18. Licensed nurse C stated and confirmed he/she did not inform resident and/or resident's legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist and that the resident and/or legal representative accepted the risk of potential adverse consequences. For resident #314, operator B failed to develop a policy and implement procedures for receiving and identifying the sample medication that included the conditions of the medication is not a controlled medication; 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	S5314		

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S5314	Continued From page 17 regarding administration; a licensed nurse or medication aide receives the medication in its original, unbroken manufacturer's package; a licensed nurse documents receipt of the medication by entering the resident's name and the medication name, strength, and quantity into a log; staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches the information on the medical care provider's order; and 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; and the resident's clinical record shall contain documentation that the resident or resident ' s legal representative has received the information and accepted the risk of potential adverse consequences.	S5314		
S5320 SS=F	26-42-205 (k) Medication Clinical Records (k) Clinical record. The administrator or operator, or the designee, shall ensure that the clinical record of each resident for whom the home manages the resident ' s medication or prefills medication containers or syringes contains the following documentation: (1) A medical care provider ' s order for each medication; (2) the name of the pharmacy provider of the resident ' s choice; (3) any known medication allergies; and (4) the date and the 12-hour or 24-hour clock time any medication is administered to the	S5320		

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S5320	Continued From page 18 resident. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(k)(4) The facility reported a census of 7 residents. The sample included 3 residents, 1 resident focus reviewed, and 1 closed record reviewed. Based on record review and interview for all 7 residents receiving facility management of medications, operator B failed to ensure the clinical record for each resident contained documentation of the 12-hour or 24-hour clock time any medication was administered to the resident. Findings included: - Review of the resident roster revealed each of the 7 residents received medication administration by certified medication aides or licensed nurses. - Record review for resident #310 revealed an admission date of 5/1/18 with diagnoses of unspecified dementia, type 2 diabetes mellitus, and essential hypertension. Functional capacity screen (FCS) dated 9/25/18 indicated resident was unable to perform management of medications. Negotiated service agreement/health care service plan (NSA/HCSP) dated 9/25/18 documented service of medication administration by certified medication aide (CMA) or licensed nurse. The October 2018 medication administration record (MAR) listed medications resident to receive with administration times listed	S5320		

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S5320	Continued From page 19 as "AM", "PM", or "HS." The MAR lacked documentation of the actual clock time each medication was administered. - Record review for resident #311 revealed an admission date of 8/31/18 with diagnoses of acute kidney failure, cerebral infarction, atrial fibrillation, and dementia. FCS dated 8/31/18 indicated resident was unable to perform management of medications. NSA/HCSP dated 8/31/18 documented service of medication administration by CMA or licensed nurse. The October 2018 MAR listed medications resident to receive with administration times listed as "AM", "PM", "HS." The MAR lacked documentation of the actual clock time each medication was administered. - Record review for resident #312 revealed an admission date of 1/10/17 with diagnoses of senile degeneration of brain, hypertension, atrial fibrillation, and type 2 diabetes mellitus. FCS dated 4/29/18 indicated resident was unable to perform management of medications. NSA/HCSP dated 4/29/18 documented service of medication administration by CMA or licensed nurse. The October 2018 MAR listed medications resident to receive with administration times listed as "AM" or "HS." The MAR lacked documentation of the actual clock time each medication was administered. Each resident's record contained a licensed nurse's request for an order from the resident's medical care provider dated 8/9/18 for liberalized times for medication pass. The licensed nurse documented medications listed as "AM" administered between 6:00 a.m. and 11:59 a.m.; "PM" administered between 1:00 p.m. and 6:59 p.m.; and "HS" at hour of sleep.	S5320		

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S5320	Continued From page 20 During an interview at 2:39 p.m. on 10/9/18, operator B stated and confirmed each resident's record lacked documentation of the actual clock time a medication was administered. Operator B failed to ensure the clinical record for each resident contained documentation of the 12-hour or 24-hour clock time any medication was administered to the resident.	S5320		