STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087210	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD SENIORS, LLC	1226 S BYRON ROAD WICHITA, KS 67209

(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 complaints #133000, #133210, #133283, #13353, and #133542 of the above home plus facility on September 17, 18, 19, 20, 24, and 25, 2018.	S 000		
S 130 SS=E	26-39-103 (g) Resident Right Finance Management (g) Management of financial affairs. The administrator or operator shall ensure that each resident is afforded the right to manage personal financial affairs and is not required to deposit personal funds with the adult care home. This STANDARD is not met as evidenced by: KAR 26-39-103(g) The facility reported a census of 4 residents. The sample included 4 residents and 1 closed record reviewed. Based on record review and interview for 2 (#7 and #8) of 4 residents sampled, registered nurse (RN)/operator A failed to ensure each resident was afforded the right to manage personal financial affairs. Findings included: - During an interview at 2:48 p.m. on 9/18/18, certified staff E stated spending money for (resident #7) and (resident #8) was stored in the medication cart lock box that stored controlled medications. Certified staff E stated records were maintained of each resident's balance in the controlled medication sign-out book.	S 130		

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

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S 130	Continued From page 1 The controlled medication sign out book contained records of each resident's money. At 5:21 p.m. on 9/18/18, RN/operator A stated he/she received $62 each month from resident #7 and $62 each month from resident #8 and kept money locked in a file cabinet in the garage. RN/operator A stated that money came up missing when these residents kept their money with them. For residents #7 and #8, RN/operator A failed to ensure each resident was afforded the right to manage personal financial affairs.	S 130		
S5026 SS=L	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(1)(B) The facility reported a census of 4 residents. The sample included 4 residents and 1 closed record reviewed, registered nurse (RN)/operator A failed to ensure 4 (#2, #5, #7, and #8) of 4 residents living in the facility were not subjected to neglect	S5026		

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S5026	Continued From page 2	S5026		

when certified staff H allegedly left residents unattended from some time after 12:28 a.m. until 6:50 a.m. 9/7/18. This failure placed all residents in immediate jeopardy for harm, injury, or death.

Findings included:

- The department received an intake at 4:48 p.m. on 9/11/18 from RN/operator A reporting that on 9/7/18 at 7:00 a.m. certified staff came to work at facility and certified staff H was not in the facility or on the property and his/her car was gone. RN/operator A reported a census of 4 residents and found 3 residents (#2, #7, and #8) in bed and 1 resident (#5) on a floor mat beside bed. RN/operator A reported certified staff H texted his/her phone at approximately 12:20 a.m. on 9/7/18 that resident #5 rolled out of bed. RN/operator did not find the text until morning and assessed resident #5 at 8:30 a.m. and found a bruise on right upper arm.

At 10:22 a.m. on 9/18/17, RN/operator A provided his/her investigation of the allegation of residents left unattended on 9/7/18. The investigation contained written narrative of the incident by RN/operator A and no written statements by certified staff H who allegedly left the facility leaving residents unattended or a written statement by certified staff D who arrived at work at 6:50 a.m. on 9/7/18 and found no employee on duty in the facility. RN/operator A documented in the narrative that he/she received a call from certified staff D reporting that he/she arrived at the facility at 6:50 a.m. finding certified staff H's bag but certified staff H's car not at facility. Certified staff D reported all residents except resident (#5) were in bed. Resident #5 was on mat beside his/her bed with pillows and blankets. RN/operator A documented that certified staff H

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S5026	Continued From page 3	S5026		

was terminated.

At 1:00 p.m. on 9/18/18, certified staff D provided a written statement of the incident at 6:50 a.m. on 9/7/18. Certified staff D documented he/she "arrived at work at 6:50 a.m., 10 minutes early for my shift. The front door was unlocked. All the lights were off. No residents were awake. No staff was present. (Resident #3) was asleep in bed, (residents #7 and #8) were both asleep in their respective beds. (Resident #5) was asleep on the floor mat beside (his/her) bed. (He/she) was covered with (his/her) comforter and had 2 pillows under (his/her) head. (Certified staff H), who was on duty overnight, was not to be found anywhere. The med cart was unlocked, but there appeared to be no keys. (His/her) bags were in the kitchen and on one of the chairs. Dishes were half way washed. Laundry was halfway folded. I called and texted (certified staff H) and got no answer or response and I called (RN/operator A) to explain the situation. Then I got (resident #5) up. (His/her) bed was half way remade with clean sheets, but (he/she) was very soaked with urine. I repeatedly asked (him/her) if (he/she) hurt anywhere. (Resident #5) kept saying no, though (he/she) had a large bruise on (his/her) right arm. The other residents did say that (resident #5) had fallen out of bed earlier that night. None of the residents were aware that (certified staff H) had gone. (Resident #8) did say that (he/she) woke to use the bathroom at some point during the night. While (he/she) was up (he/she) heard knocking on the door and went to investigate. (Resident #8) stated it was (certified staff H) who had locked (self) out. I was asked to write an incident report by (RN/operator A)."

At 8:57 a.m. on 9/19/18, surveyor met with certified staff H for an interview and to request a

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written statement. Certified staff H stated he/she did not leave the facility leaving residents unattended on 9/7/18. He/she stated he/she left the facility at 7:00 a.m. on 9/7/18 when he/she was relieved by certified staff D. Certified staff H stated he/she did not count controlled medications that morning with certified staff D who was not a medication aide. Certified staff H stated he/she forgot to leave the medication cart keys in the facility lock box and put the keys in his/her pocket. Certified staff H stated that RN/operator A did mention to him/her that he/she left facility before day shift aide arrived "but I dismissed it because I did not leave early." Certified staff H stated RN/operator A had taken him/her off the schedule but was not told why by RN/operator A. Surveyor asked certified staff H about the fall experienced by resident #5. Certified staff H stated the resident did not fall but had scooted self to edge of bed, certified staff H heard the bed alarm sounding and found resident on floor mat. Certified staff H stated he/she called RN/operator A who instructed him/her to ask resident to do range of motion, take vital signs, and assist resident #5 back into bed. Certified staff H provided a written statement that did not include any other information than what was stated in his/her interview.

During an interview at 1:08 p.m. on 9/19/18, RN/operator A stated he/she did not have a record on cell phone that certified staff H called him/her on 9/7/18 to report resident #5's fall. RN/operator A denied talking on phone with certified staff H and instructing him/her on care of resident after the fall. RN/operator A provided his/her phone with a text from certified staff H at 12:28 a.m. 9/7/18 to report resident #5 rolled off the bed and no injuries.

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S5026	Continued From page 5 Record reviews, interviews, and observations for residents revealed the following: - Resident #5 admitted to the facility on 11/1/17 with diagnoses of bone cancer, schizophrenia, and Alzheimer's disease. Functional capacity screen dated 8/13/18 indicated resident required physical assistance with bathing, dressing, toileting, transferring, mobility and eating; unable to perform management of medications and treatments; 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 8/13/18 documented certified staff to provide physical assistance with all activities of daily living and interventions to address resident's risk of falls as bed in lowest position, fall mat beside bed, and body alarm when in bed. At 11:19 a.m. on 9/19/18 surveyor spoke with resident #5 while he/she sat in a wheelchair in his/her room. Surveyor observed a large purple bruise covering the inner aspect of resident's right upper arm. Resident confirmed he/she fell but could not remember specifics of fall. During time in facility, surveyor observed that resident sat in a recliner, sat in a wheelchair, or rested in bed and required one-person assistance to transfer. - Resident #8 admitted to the facility on 5/17/17 with diagnoses of type 2 diabetes mellitus and ischemic cardiomyopathy. Functional capacity screen dated 8/10/18 indicated resident required supervision with bathing, dressing, toileting, transferring, mobility, and eating; was unable to perform management of medications and treatments; and was at risk for falls. Negotiated service agreement/health care service plan dated	S5026		

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S5026	Continued From page 6 8/10/18 documented certified staff to supervise resident with activities of daily living. During an interview at 11:41 a.m. on 9/19/18, resident #8 stated he/she could not remember if he/she let certified staff H in house after employee locked self out of house. Resident #8 confirmed resident #5 recently fell during the night around 1:30 a.m. but he/she could not remember the name of the employee working at the time. During time in facility, surveyor observed resident walked independently with a walker. - Resident #7 admitted to the facility on 8/3/17 with diagnoses of atrial fibrillation, dementia, and history of stroke. Functional capacity screen dated 8/3/18 indicated resident was unable to walk; required physical assistance with bathing, dressing, toileting, and transferring; required supervision when eating; unable to perform management of medications and treatments; and experienced impaired short-term memory, long-term memory, memory recall, and decision making. Negotiated service agreement/health care service plan dated 8/3/18 documented certified staff to provide physical assistance with activities of daily living. - Resident #2 admitted to the facility on 6/13/18 with diagnoses of atrial fibrillation, osteoarthritis, hypertension, and chronic obstructive pulmonary disease. Functional capacity screen dated 8/13/18 recorded resident required supervision with transfer, physical assistance with bathing, dressing, toileting, walking/mobility, bladder incontinence, facility managed medications, experienced short-term memory loss, decision making, impaired decision making, and falls/unsteadiness. Negotiated service agreement dated 6/13/18 recorded resident	S5026		

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independent with transfer, required stand by assistance with bathing, dressing, ambulation, and toileting assist morning/evening. Health care service plan dated 8/13/18 recorded staff to administer medications, physical assistance with bathing, supervision with dressing, standby assistance with toileting, and ambulation with walker.

During an interview at 10:00 a.m. on 9/20/18, resident #2 stated he/she did not remember using call button on 9/7/18. Resident can transfer self to and from toilet during night if needed. Resident further stated would not know if anyone fell during night or if the only staff on duty left the facility as his/her door kept shut most of time.

RN/operator A failed to ensure 4 (#2, #5, #7, and #8) of 4 residents living in the facility were not subjected to neglect when certified staff H allegedly left residents unattended. This failure placed residents in immediate jeopardy for harm, injury, or death.

The immediate jeopardy was corrected at 2:27 p.m. on 9/20/18, when RN/operator A provided a written plan to ensure certified or licensed personnel in the facility at all times to supervise and provide care to residents as follows:
"Plan of correction to assure staff, esp. (especially) at night do not leave the facility:
1) Education to staff that no one is to leave during their shift without a staff member or myself present to cover that time gone. This also must be approved by supervisor.
2) Operator has started calling the home phone to assure staff are present during their shift.
3) Plan is to install security cameras ASAP (as soon as possible).

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S5026	Continued From page 8 4) Periodic drop-in by operator to assure all is well with residents/staff.	S5026		
S5028 SS=E	26-42-101 (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 home 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 26-42-101(f)(3)(C)	S5028		

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S5028	Continued From page 9	S5028		

The facility reported a census of 4 residents. The sample included 4 residents and 1 closed record reviewed. Based on record review and interview for 4 (#2, #5, #7, and #8) of 4 residents sampled, registered nurse (RN)/operator A failed to report an allegation of neglect to the department within 24 hours of the allegation and failed to conduct a thorough investigation.

Findings included:

- The department received an intake at 4:48 p.m. on 9/11/18 from RN/operator A reporting that on 9/7/18 at 7:00 a.m. certified staff came to work at facility and certified staff H was not in the facility or on the property and his/her car was gone. RN/operator A reported a census of 4 residents and found 3 residents (#2, #7, and #8) in bed and 1 resident (#5) on a floor mat beside bed. RN/operator A reported certified staff H texted his/her phone at approximately 12:20 a.m. on 9/7/18 that resident #5 rolled out of bed. RN/operator did not find the text until morning and assessed resident #5 at 8:30 a.m. and found a bruise on right upper arm.

At 10:22 a.m. on 9/18/17, RN/operator A provided his/her investigation of the allegation of residents left unattended on 9/7/18. The investigation contained written narrative of the incident by RN/operator A and no written statements by certified staff H who allegedly left the facility leaving residents unattended or a written statement by certified staff D who arrived at work at 6:50 a.m. on 9/7/18 and found no employee on duty in the facility. RN/operator A documented in the narrative that he/she received a call from certified staff D reporting that he/she arrived at the facility at 6:50 a.m. finding certified staff H's bag but certified staff H's car not at facility.

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S5028	Continued From page 10 Certified staff D reported all residents except resident (#5) were in bed. Resident #5 was on mat beside his/her bed with pillows and blankets. RN/operator A documented that certified staff H was terminated. During an interview at 11:03 a.m. on 9/18/18, RN/operator A stated she did not request a written statement from witnesses certified staff D or certified staff H as part of his/her investigation. RN/operator A stated he/she talked with resident #2 who stated that on 9/7/18 he/she activated call button and certified staff H stood in hallway but did not come into resident's room. RN/operator A stated resident #8 reported he/she heard someone knocking on door and resident #8 went to door to let certified staff H back into the facility but resident #8 could not recall the time. RN/operator A's investigation did not include the interviews with resident #2 or resident #8. RN/operator A failed to report an allegation resident neglect to the department within 24 hours of the allegation and failed to conduct a thorough investigation.	S5028		
S5185 SS=E	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical	S5185		

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S5185	Continued From page 11 record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(c) The facility reported a census of 4 residents. The sample included 4 residents and 1 closed record reviewed. Based on observations, record reviews, and interviews for 2 (#5 and #2) of 4 residents sampled, registered nurse (RN)/operator A failed to ensure that when the resident's negotiated service agreement (NSA) included the provision of a therapeutic diet or a mechanically altered diet, a medical care provider's order shall be on file in the resident's clinical record, and the diet shall be prepared according to instructions from a medical care provider or licensed dietitian. Findings included: - Resident #5 admitted to the facility on 11/1/17 with diagnoses of bone cancer, schizophrenia, and Alzheimer's disease. Functional capacity screen dated 8/13/18 indicated resident required physical assistance with eating and experienced impaired short -term memory, long-term memory, memory recall, and decision making. NSA dated 8/13/18 documented resident to receive a mechanical soft diet to full liquids. The NSA documented resident pocketed food (in	S5185		

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S5185	Continued From page 12	S5185		

mouth) at times and when he/she did this, staff members were to provide a full liquid diet. Resident's record lacked a medical care provider's order for a mechanical soft diet or full liquid diet.

At 2:12 p.m. on 9/17/18, surveyor observed resident #5 sitting in a recliner in the living room with food on a table next to the resident. Food items included a whole hot dog on a bun, a dish of cottage cheese, and a bottle of Glucerna. Certified staff D stated resident refused to eat lunch today as the reason food remained on tray.

During an interview at 3:46 p.m. on 9/17/18, RN/operator A stated staff members did not have written instructions from a medical care provider or licensed dietitian for the preparation of a mechanical soft diet and a full liquid diet.

- Resident #2 admitted to facility on 6/13/18 with diagnoses of atrial fibrillation, osteoarthritis, hypertension, and chronic obstructive pulmonary disease.

Functional capacity screen dated 8/13/18 (significant change) indicated resident independent with eating and experienced short-term memory loss and decision making.

The NSA dated 6/13/18 recorded resident on a low salt, low fat diet. Resident's record lacked a medical care provider's order for a mechanical soft diet or full liquid diet.

Interview on 9/18/18 at 10:35 a.m. with resident #2 stated he/she should be on a low fat/low sodium diet but food here not low sodium or low-fat foods.

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	B087210	A. BUILDING: _____ B. WING _____	09/25/2018

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EMERALD SENIORS, LLC	1226 S BYRON ROAD WICHITA, KS 67209

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S5185	Continued From page 13 On 9/18/18 at 10:40 a.m. observed a bowl of dry cereal resident #2 was eating with a spoon. Resident #2 stated he/she did not want to pour Ensure over it and will eat it dry. On 9/18/18 at 10:45 p.m. interview with RN/operator A and certified staff D stated no therapeutic diets served here and resident #2 lacked written instructions from his/her medical care provider or licensed dietitian on how to prepare low sodium/low fat diet. For residents #5 and #2, RN/operator A failed to ensure that when the resident's negotiated service agreement (NSA) included the provision of a therapeutic diet or a mechanically altered diet, a medical care provider's order shall be on file in the resident's clinical record, and the diet shall be prepared according to instructions from a medical care provider or licensed dietitian.	S5185		
S5186 SS=F	26-42-206 (d) Dietary Services Menus (d) The menus shall be planned in advance and in accordance with the dietary guidelines adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(d) The facility identified a census of 4 residents. The sample included 4 residents and 1 closed record review. Based on record review, observation, and interview for 4 (#2, #5, #7, and #8) of 4 residents sampled, registered nurse (RN)/operator A failed to ensure the menus were	S5186		

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S5186	Continued From page 14 planned in advance and in accordance with the dietary guidelines adopted by reference in K.A.R. 26-39-105. Findings included: - On 9/17/18 at 2:07 p.m. observed 7 pork chops in crock pot. Certified staff D stated he/she put pork chops in crock pot approximately 1:00 p.m. Certified staff D further stated was having barbeque pork, mac and cheese for dinner. Menu identified tuna noodle bake with soup or sandwich as alternate. Certified staff D stated was cooking pork chops because there was no tuna in facility. The menu posted for the month of September 2018 recorded 15 of 30 days breakfast served with no meat or protein. Cereal served 15 of 20 days. 8 of 30 days the menu lacked information or instructions on how or what to make for lunch. 16 of 30 days lacked information or instructions on what or how to make dinner. Interview on 9/17/18 at 3:35 p.m. with certified staff D stated he/she filled out the menu as he/she would at home for his/her family. Interview on 9/17/18 at 3:45 p.m. with RN/operator A stated, "Menu made out monthly by certified staff." For all residents, the RN/operator A failed to ensure the menus were planned in advance and in accordance with the dietary guidelines adopted by reference in K.A.R. 26-39-105.	S5186		

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S5251	Continued From page 15	S5251		
S5251 SS=D	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of 4 residents. The sample included 4 residents and 1 closed record reviewed. Based on record review and interview for 1 (#5) of 4 residents sampled, registered nurse/operator A failed to ensure the resident's record contained documentation of all incidents, symptoms, and indications of injury including the date, time of occurrence, action taken, and results of the action. Findings included: - The department received an intake at 4:48 p.m. on 9/11/18 from RN/operator A reporting that on 9/7/18 at 7:00 a.m. certified staff came to work at facility and certified staff H was not in the facility or on the property and his/her car was gone. RN/operator A reported a census of 4 residents and found 3 residents (#2, #7, and #8) in bed and 1 resident (#5) on a floor mat beside bed. RN/operator A reported certified staff H texted his/her phone at approximately 12:20 a.m. on 9/7/18 that resident #5 rolled out of bed. RN/operator A did not find the text until morning and assessed resident #5 at 8:30 a.m. and found a bruise on right upper arm.	S5251		

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S5251	Continued From page 16 Record review on 9/17/18 revealed resident admitted to the facility on 11/1/17 with diagnoses of bone cancer, schizophrenia, and Alzheimer's disease. Functional capacity screen dated 8/13/18 indicated resident required physical assistance with bathing, dressing, toileting, transferring, mobility and eating; unable to perform management of medications and treatments; 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 8/13/18 documented certified staff to provide physical assistance with all activities of daily living and interventions to address resident's risk of falls as bed in lowest position, fall mat beside bed, and body alarm when in bed. The last entry on the nurse's notes was dated 8/30/18. The nurse's notes lacked an entry dated 9/7/18 documenting the resident fell from bed onto the mat beside the bed, findings of the nurse's assessment, action taken and results of action. At 4:47 p.m. on 9/17/18 surveyor asked for a copy of the page of the nurse's notes with only the 8/30/18 entry. When RN/operator A brought the copy to the surveyor, RN/licensed nurse A had documented the following: 9/2/18 at 8:30 p.m. (certified staff H) reported resident fell from toilet while (certified staff H) left room to get clean clothes. Resident denied injuries and (certified staff H) able to get resident up from floor.	S5251		

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S5251	Continued From page 17 9/3/18 at 8:00 a.m. (RN/operator A) assessed resident and found no signs/symptoms or injury. 9/7/18 (no time, RN/operator A) received a text from (certified staff H) that resident had rolled out of bed with no injuries. Floor mat was in place and bed in low position. 9/7/18 (no time,) RN/operator A documented the time of the text message was 0028 (12:28 a.m.). 9/7/18 8:30 a.m. RN/operator A documented he/she arrived at facility to find resident #5 in bed. No complaints of discomfort. Resident does have a bruise to right upper medical arm. Resident denies pain and able to move all extremities. Hospice nurse and medical care provider notified. RN/operator A stated he/she had just now made the entries in the resident's record for 9/2/18, 9/3/18, and 9/7/18. RN/operator A failed to ensure the record for resident #5 contained documentation of all incidents, symptoms, and indications of injury including the date, time of occurrence, action taken, and results of the action.	S5251		
S5315 SS=F	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	S5315		

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S5315	Continued From page 18 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)(1) The facility identified a census of 4 residents. The sample included 4 residents and 1 closed record reviewed. Based on record review, observations, and interviews for 4 (#2, #5, #7, and #8) of 4 residents sampled receiving facility management of medications, registered nurse (RN)/operator A and medications aides failed to store non-controlled and controlled medications in a locked medication cart and failed to store	S5315		

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S5315	Continued From page 19	S5315		

controlled medications requiring refrigeration in a locked compartment within a locked refrigerator.

Findings included:

- Review of the resident roster revealed the facility provided medication management to each of the 4 residents.

During tour of facility on 9/17/18 at 2:05 p.m. surveyor observed medication cart unlocked with keys on top of the medication cart. At 2:20 p.m. medication cart continued to be unlocked. RN/operator A confirmed medication cart was not secured, tossed keys to certified staff D, and instructed to keep keys at all times with medication cart locked.

On 9/17/18 at 2:25 p.m. surveyor observed the medication refrigerator; not secured, with a Tupperware container on top shelf. The container contained liquid morphine sulfate 30 milliliters (ML) (narcotic for pain), lorazepam 30 ML (for anxiety), and a 2 milligram (MG) vial of lorazepam Intramuscular (IM) (for anxiety) all labeled for resident #5.

Interview on 9/17/18 at 2:45 p.m. with RN/operator A stated was not aware controlled medications stored in the refrigerator had to be stored in a locked compartment if refrigerator door locked. RN/operator A confirmed the medication refrigerator door was not locked and contained controlled medications.

For all residents, RN/operator A and medications aides failed to store non-controlled and controlled medications in a locked medication cart and failed to store controlled medications requiring refrigeration in a locked compartment within a

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S5315	Continued From page 20 locked refrigerator.	S5315		
S5316 SS=E	26-42-205 (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 home 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 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 26-42-205(i)(1)(A)(B) The facility identified a census of 4 residents. The sample included 4 residents and 1 closed	S5316		

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S5316	Continued From page 21	S5316		

record review. For 1 (#5) of 4 residents sampled, registered nurse (RN)/operator A and certified medication aides failed to maintain records of medications managed by the facility in sufficient detail for an accurate reconciliation. RN/operator A further failed to ensure two licensed nurses, or a licensed nurse and a licensed pharmacist destroyed controlled medications and biologicals.

Findings included:

- Resident #5 admitted to the facility on 11/1/17 with diagnoses of bone cancer, schizophrenia, and Alzheimer's disease.

Functional capacity screen dated 8/13/18 indicated resident unable to manage medications and experienced impaired short -term memory, long-term memory, memory recall, and decision making.

Negotiated service agreement dated 8/13/18 documented medications managed and administered by certified medication aides or licensed nurses.

Written order dated 5/31/18 recorded morphine 20 milligrams per milliliter (ml), administer 0.25 to 1 ml sublingual every hour as needed for air hunger/pain.

At 2:45 p.m. on 9/17/18 observed morphine sulfate liquid in medication refrigerator. The bottle contained small amount of clear liquid. Review of narcotic count sheet dated 9/10/18 recorded 7 ML left in bottle. No other entry noted after 9/10/18. Operator/RN A stated he/she counted all the narcotics in medication cart and did not count the morphine liquid kept in the refrigerator. RN/operator A measured liquid in

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S5316	Continued From page 22 morphine bottle and identified only 0 .5 ml remained in the bottle. RN/operator A confirmed 6.5 ml missing from the bottle. At 11:05 a.m. on 9/18/18 operator/RN A stated he/she wasted the morphine 0.5 ml last night with certified staff D and further stated did not have a policy or procedure for narcotic reconciliation or destruction. For resident #5, RN/operator A and certified medication aides failed to maintain records of medications managed by the facility in sufficient detail for an accurate reconciliation. RN/operator A further failed to ensure two licensed nurses, or a licensed nurse and a licensed pharmacist destroyed controlled medications and biologicals.	S5316		