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	N011007	A. BUILDING: _____ B. WING _____	08/29/2018

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named residential health care facility conducted on 8-27-18, 8-28-18 and 8-29-18.	S 000		
S3155 SS=D	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility 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 26-41-204(a) The facility reported a census of 18 residents. The sample included 3 residents. Based on observation, record review and interview for 1 (#521) of 1 sampled resident with siderails, the operator/licensed nurse failed to provide or coordinate the provision of necessary health care services that met the needs of the resident regarding use of siderails to include a safety assessment and instructions for use in the negotiated service agreement/health care service plan. Findings included: - Record review for Resident #521 revealed	S3155		

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S3155	Continued From page 1	S3155		

admission on 4-20-11 with diagnoses Friedreich's Ataxia, Type 2 Diabetes Mellitus, Hypertension, Hypokalemia, Urinary Incontinence, and Hyperlipidemia.

The Functional Capacity Screen dated 7-29-18 recorded resident required physical assistance with eating; unable to perform bathing, dressing, toileting, transfers, walking/mobility and management of medications and treatments. Incontinent of urine. Cognition: problems with short term memory, memory/recall and decision-making. Current problems/risks identified included falls/unsteadiness and impaired decision-making.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 7-29-18 recorded services for total assistance with bathing, dressing, toileting, transfers, mobility per wheelchair and facility to manage medications.

The NSA/HCSP lacked documentation of indication and use of siderails including documentation of a safety assessment performed prior to use of the devices. The record lacked documentation of use of the siderails.

Observation on 8-27-18 at 2:48 pm of Resident #521's room during entrance tour accompanied by Operator/licensed nurse revealed a hospital bed with four half bed rails, two at the top and two at the bottom. The rails were attached to the bed frame and all rails were up and locked in position. The right side of the bed was against the wall; the rails toward the outside of the bed had pillows attached. The resident failed to demonstrate an ability to lower the siderails, but nodded head yes when asked if he/she felt more secure with all the rails up. Observations during survey revealed

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S3155	Continued From page 2 that staff instructed resident to hold onto the upper rails when rolling over in bed during cares. The resident was able to follow these instructions. Interviews on 8-27-18 at 2:48 pm and 3:43 pm with operator/licensed nurse stated the hospital bed belonged to the resident and that the rails "had always been on there." Stated the resident uses the rails to assist with turning and when getting in and out of bed. Confirmed the use of the siderails was not on the NSA/HCSP. Further confirmed the facility lacked a policy for use of siderails in the facility including requirement for safety assessment prior to use and ongoing as condition changes. For Resident #521, the operator/licensed nurse failed to coordinate the provision of necessary health care services that met the needs of the resident regarding use of siderails to include a safety assessment and instructions for use in the negotiated service agreement/health care service plan.	S3155		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for	S3200		

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S3200	Continued From page 3 which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 18 residents. The sample included 3 residents. Based on record review and interview for 1 (#521) of 3 sampled residents, the operator/licensed nurse failed to ensure all medications and biologicals are administered in accordance with a medical care provider's written order and professional standards of practice. Findings included: - Record review for Resident #521 revealed admission on 4-20-11 with diagnoses Friedreich's Ataxia, Type 2 Diabetes Mellitus, Hypertension, Hypokalemia, Urinary Incontinence, and Hyperlipidemia. The Functional Capacity Screen dated 7-29-18 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 7-29-18 recorded services for facility management of medications. Physician Orders: Chlordiazepoxide (sedative/hypnotic) 10 mg	S3200		

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S3200	Continued From page 4	S3200		

(milligrams) 1 capsule by mouth as needed for anxiety. (original order 6-21-18).
Tylenol (pain reliever/fever reducer) 500 mg 2 tabs (tablets) every 4 hours as needed. The order lacked documentation of indication for administration.

Review of Medication Administration Records (MAR) documentation for administration of PRN (as needed) medications revealed:

June 2018
Tylenol 500 mg two tablets, documented as given 19 times by Certified Staff C, E, F, and G for "pain all over".
Chlordiazepoxide (sedative/hypnotic) 10 mg 1 capsule, documented as given 5 times by Certified Staff B and C for "anxiety".

July 2018
Tylenol 500 mg two tablets, documented as given 31 times by Certified Staff C, E, and F for "pain all over".
Chlordiazepoxide 10 mg 1 capsule documented as given 11 times by Certified Staff B, C, D, E and G for "anxiety".

August 2018
Tylenol 500 mg two tablets documented as given 27 times by Certified Staff B, C, E, F, G, H for "pain all over".
Chlordiazepoxide 10 mg 1 capsule documented as given 2 times by Certified Staff C and G for "anxiety".

All entries lacked documentation of instruction from a licensed nurse to administer medications on an as needed basis which requires assessment by a nurse. The record further lacked follow up documentation of assessment by

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S3200	Continued From page 5 the nurse. Interview on 8-28-18 around 2:30 pm with Certified Staff B confirmed he/she had administered Chlordiazepoxide to the resident for "anxiety" and that the resident "usually gets Tylenol in the mornings". "I worked night shift one night, he/she would be moving, so I thought he/she was in pain, I'm guessing he/she was getting it (Tylenol) for pain..(resident was) antsy, rolling to one side like his/her side was hurting. I asked if everything was ok, he/she didn't really say anything." Regarding administration of Chlordiazepoxide, stated it was administered when resident was "real antsy" Stated resident "flips feet to side" as if wanting to get out of bed. Stated he/she calls operator/licensed nurse for instruction to administer Chlordiazepoxide but confirmed this was not documented on the MAR. Interview on 8-28-18 at 11:37 am with operator/licensed nurse stated resident usually remains in bed, only getting out of bed for showers and when changing bed. Stated staff checks resident hourly and he/she will "rattle the rail if he/she wants someone to come, won't use call light." Stated the staff always call first before administering controlled medications (Chlordiazepoxide) but not Tylenol. Confirmed the record lacked documentation of instruction to certified staff to give the medications or documentation of follow up assessment by a licensed nurse in the record. For Resident #521, the operator/licensed nurse failed to ensure medications were administered in accordance with professional standards of practice when PRN medications were administered by certified staff without instruction from a licensed nurse.	S3200		

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S3226 SS=F	26-41-205 (l) (1) Medication Regimen Review Contents (l) (1) The medication regimen review shall identify any potential or current medication-related problems, including the following: (A) Lack of clinical indication for use of medication; (B) the use of a subtherapeutic dose of any medication; (C) failure of the resident to receive an ordered medication; (D) medications administered in excessive dosage, including duplicate therapy; (E) medications administered in excessive duration; (F) adverse medication reactions; (G) medication interactions; and (H) lack of adequate monitoring. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l)(1) The facility reported a census of 18 residents. The sample included 3 residents. The operator/licensed nurse failed to ensure the medication regimen review identified any potential or current medication-related problems as evidenced by record review and interview for 3 (#521, #368, #947) of 3 sampled residents and affecting all resident with facility managed medications. Findings included:	S3226		

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S3226	Continued From page 7	S3226		

- Record review for Resident #521 revealed admission on 4-20-11 with diagnoses Friedreich's Ataxia, Type 2 Diabetes Mellitus, Hypertension, Hypokalemia, Urinary Incontinence, and Hyperlipidemia. The Functional Capacity Screen dated 7-29-18 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 7-29-18 recorded services for facility to manage medications.

For Resident #521, a Medication Administration Record for August 2018 lacked documentation of an indication for use for the following medications:
Aspirin Enteric Coated 81 mg (milligrams)
Citalopram 20 mg
Compvite Silver
Furosemide 40 mg
Glipizide Extended Release 2.5 mg
Lisinopril 5 mg
Lovastatin 10 mg
Megestrol 40 mg
Nitrofurantoin 100 mg
The resident record contained an unlabeled form with list and code numbers on left side for Charting Errors, Administration Errors, and Apparent Irregularities. The right side of the form contained columns for Date, Code numbers and signature of the pharmacist performing the regimen review. The list of irregularities lacked requirement for indication for use.

- Record review for Resident #368 revealed admission on 4-19-13 with diagnoses Pruigo Nodularis, Iron-Deficiency Anemia, Dysphagia, Edema, Chronic Kidney Disease Stage 3, Type 2 Diabetes Mellitus, Hypertension, Hyperlipidemia,

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S3226	Continued From page 8 Osteoarthritis, Sleep Apnea and Gastroesophageal Reflux Disease. The Functional Capacity Screen dated 4-19-18 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 4-19-18 recorded service for facility to manage medications. For Resident #368, a Medication Administration Record for August 2018 lacked documentation of an indication for use for the following medications: Atenolol 50 mg Calcium with vitamin D Cetirizine 10 mg Combivent Respimat inhaler Cranberry plus vitamin C Colace 100 mg Donepezil 10 mg Duloxetine 60 mg Fish Oil 1200 mg Furosemide 40 mg Januvia 100 mg Lisinopril 40 mg Omeprazole 20 mg Pravastatin 20 mg Sarna Lotion Tresiba Flextouch 100 units/milliliter Vitamin B-12 1-00 micrograms The resident record contained an unlabeled form with list and code numbers on left side for Charting Errors, Administration Errors, and Apparent Irregularities. The right side of the form contained columns for Date, Code numbers and signature of the pharmacist performing the regimen review. The list of irregularities lacked requirement for indication for use.	S3226		

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S3226	Continued From page 9 - Record for Resident #947 lacked documentation of a medication regimen review. Facility policy for "Medication Management" stated" N. A drug regimen review shall identify any potential or current drug related problem in the following manner: a. lack of clinical indication for drug. b. subtherapeutic dose of any drug. c. failure of the resident to receive ordered drug. d. drugs administered in excessive dosage, including duplicate therapy. e. adverse drug reactions. f. drug interactions. g. lack of adequate monitoring. Interview on 8-28-18 at 1:05 pm with operator/licensed nurse confirmed the medications listed on the medication administration record and physician's order sheets lacked documentation of an indication for use (diagnosis). Stated has never had the diagnosis listed with the medications. Confirmed the facility failed to follow its policy. For all residents with facility managed medications, the operator/licensed nurse failed to ensure the medication regimen review identified lack of clinical indication for use of medications.	S3226		