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	N008013	A. BUILDING: _____ B. WING _____	08/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MAPLETON ANDOVER, LLC	1419 W CENTRAL AVE ANDOVER, KS 67002

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named assisted living facility conducted on 8/28,29/2018.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (A) (1) (2) (3) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review and interview, the Administrator failed to ensure that designated facility staff completed the Negotiated Service Agreement to include a description of the outside services the resident received, identification of the provider of each service, and identification of the party responsible	S3085		

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

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S3085	Continued From page 1 for payment of the outside service for 2 (#828,829) of 3 residents. -- Review of resident #828's medical record revealed the resident admitted into the facility on 6/29/18 with diagnoses of diabetes, congestive heart failure, reflux disease, hypertension and bipolar disease. Review of the resident's functional capacity screen dated 6/29/18 revealed the resident needed physical assistance with management of medications and medical treatments. It also revealed the resident had no cognitive deficit and could communicate without difficulties and tired noticeably most days. Review of the negotiated service agreement not signed by the resident or power of attorney, dated 6/29/18 revealed the facility staff provided assistance with medication administration. It identified the resident received Home health through medicare for physical therapy and occupational therapy. The negotiated service agreement and amended service agreements lacked identification the resident received services from licensed clinical social worker, what the service was and who was responsible for payment of the service. - Review of resident #829's record revealed he/she admitted to the facility on 8/6/18 with diagnoses of diabetes, hypertension, thyroid disease, kidney disorder and recent femur fracture. Review of the functional capacity screen dated 8/6/18 revealed the resident had no cognitive deficit and needed assistance with bathing.	S3085		

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S3085	Continued From page 2 Review of the negotiated service agreement dated 8/6/18 identified the staff assisted with transfers with bathing. It also revealed the resident received oxygen services through OneSource billed through medicare. He/she also received home health through medicare for physical and occupational therapy. The negotiated service agreement lacked information regarding services provided by licensed clinical social worker , what service was provided and who paid for the service. During an interview on 8/28/28 at 4:07 PM administrative staff A and administrative nursing staff B reported they did not realize the licensed clinical social worker was considered an outside provider. The administrator failed to ensure the negotiated service agreement include a description of the outside services the resident received, identification of the provider of each service, and identification of the party responsible for payment of the outside service for 2 (#828,829) of 3 residents.	S3085		
S3095 SS=D	26-41-202 (f) NSA Refusal of Service (f) If a resident or the resident's legal representative refuses a service that the administrator or operator, the licensed nurse, the resident's medical care provider, or the case manager believes is necessary for the resident's health and safety, the negotiated service agreement shall include the following: (1) The service or services refused; (2) identification of any potential negative outcomes for the resident if the service or services are not provided;	S3095		

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S3095	Continued From page 3 (3) evidence of the provision of education to the resident or the resident ' s legal representative of the potential risk of any negative outcomes if the service or services are not provided; and (4) an indication of acceptance by the resident or the resident's legal representative of the potential risk. . This REQUIREMENT is not met as evidenced by: KAR 202(f) The facility identified 7 residents. The sample included 3 residents. Based on record review and interview for 1 (#830) of 3 residents sampled, the administrator failed to ensure the Negotiated Service Agreement (NSA) included services for refusal of Humalog insulin, enoxaparin (blood thinner), accu checks (finger stick blood sugars); identify potential negative outcome if services not provided; evidence of the provision of education to the resident of any negative outcomes if the services are not provided; and an indication of acceptance by the resident of the potential risk for not taking medications insulin and enoxaparin. Findings included: - Record review for resident #830 on 8-28-18 revealed an admit date of 8-16-18 with diagnoses of insulin dependent diabetic, methicillin resistant staff aureus to wound on left foot from great toe amputation, right above knee amputation 50 years ago, hypertension, and gout. The functional capacity screen dated 8-16-18 recorded facility staff to manage medications and treatments and independent with cognition.	S3095		

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S3095	Continued From page 4 The NSA/health care service plan (HCSP) dated 8-16-18 recorded, "the staff will put the needle on the insulin pen, prime the pen per manufacturer's instructions, then dial the dosage. I (resident) will confirm the dosage is correct, prepare the site, and self-administer the insulin with verbal cues and prompting." The physician orders dated 8-16-18 recorded resident to receive enoxaparin sodium subcutaneous (SQ) 40 milligrams daily at 8:00 AM and Humalog kwikpen SQ per sliding scale insulin according to accu checks (finger stick blood sugar) at 7:00 AM, 11:00 AM, 3:00 PM, and 8:00 PM results: 150-199 = 1 unit, 200-248 = 2 units, 250-299 = 3 units, call physician if blood sugar is greater than 300. Review of the medication administration record dated 8-16-18 identified resident refused sliding scale insulin, enoxaparin, and accu checks. Interview on 8-28-18 at 11:20 AM with administrative nursing staff B stated and confirmed the NSA lacked documentation for refusal of services for accu checks, insulin, and enoxaparin. Interview on 8-28-18 at 3:00 PM with resident stated, "he/she refused accu checks, insulin, and blood thinner (enoxaparin) because he/she did not need the medication and knew if he/she needed insulin." For resident #830, the administrator failed to ensure the NSA included services for refusal of Humalog insulin, enoxaparin, accu checks; identify potential negative outcome if services not provided; evidence of the provision of education	S3095		

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S3095	Continued From page 5 to the resident of any negative outcomes if the services are not provided; and an indication of acceptance by the resident of the potential risk for not taking medications insulin and enoxaparin.	S3095		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 7 residents. Based on record review and interview the administrator failed to ensure designated staff had each individual involved in the development of the negotiated service agreement sign the agreement for 2 (#828 and #830) of 3 residents. Findings included: - Review of resident # 828's medical record revealed the resident admitted into the facility on 6/29/18 with diagnoses of diabetes, congestive heart failure, reflux disease, hypertension and bipolar disease. Review of the resident's functional capacity screen dated 6/29/18 revealed the resident needed physical assistance with management of medications and medical treatments. It also	S3101		

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S3101	Continued From page 6 revealed the resident had no cognitive deficit and could communicate without difficulties. Review of the negotiated service agreement dated 6/29/18 lacked a signature of the resident and/or responsible party. The amended negotiated service agreements dated 7/3/18 and 7/30/18 lacked signatures of the resident and/or responsible party. During an interview on 8/28/18 at 11:05 AM administrative nursing staff B reported he/she had a care plan meeting with the family and had all of the above paperwork but forgot to give it to the family to sign. - Record review for resident #830 on 8-28-18 revealed an admit date of 8-16-18 with diagnoses of insulin dependent diabetic, methicillin resistant staff aureus to wound on left foot from great toe amputation, right above knee amputation 50 years ago, hypertension, and gout. The NSA dated 8-16-18 contained the signature of administrator, administrative nursing staff B, dated8-16-18. The NSA lacked the signature of resident or responsible party. The administrator failed to ensure designated staff obtained signatures of all parties involved in the completion of the negotiated service agreement and amended agreements for residents #828 and #830.	S3101		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage	S3175		

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S3175	Continued From page 7 medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 205(a)(1) The facility identified a census of 7 residents. The sample included 3 residents. Based on record review, interview, and observation for 1 (#830) of 3 residents sampled, the licensed nurse failed to perform an assessment and determine resident #830 could safely and accurately self-inject insulin and enoxaparin (blood thinner) without staff assistance and complete an assessment before resident initially begins self-administration of insulin and enoxaparin. Findings included: - Record review for resident #830 on 8-28-18 revealed an admit date of 8-16-18 with diagnoses of insulin dependent diabetic, methicillin resistant staff aureus to wound on left foot from great toe amputation, right above knee amputation 50	S3175		

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S3175	Continued From page 8 years ago, hypertension, and gout. The functional capacity screen dated 8-16-18 recorded facility staff to manage medications and treatments and independent with cognition. The negotiated service agreement/health care service plan dated 8-16-18 recorded, "the staff will put the needle on the insulin pen, prime the pen per manufacturer's instructions, then dial the dosage. I (resident) will confirm the dosage is correct, prepare the site, and self-administer the insulin with verbal cues and prompting. The physician orders dated 8-16-18 recorded resident to receive enoxaparin sodium subcutaneous (SQ) 40 milligrams daily at 8:00 AM and Humalog kwikpen SQ per sliding scale insulin according to accu checks (finger stick blood sugar) at 7:00 AM, 11:00 AM, 3:00 PM, and 8:00 PM results: 150-199 = 1 unit, 200-248 = 2 units, 250-299 = 3 units, call physician if blood sugar is greater than 300. Interview on 8-29-18 at 11:20 AM with licensed nurse stated he/she did not conduct a self-medication assessment to determine if resident could safely self-administer enoxaparin or Humalog insulin. For resident #830, the licensed nurse failed to perform an assessment and determine resident could safely and accurately self-inject insulin and enoxaparin (blood thinner) without staff assistance and complete an assessment before resident initially begins self-administration of insulin and enoxaparin.	S3175		

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S3200	Continued From page 9	S3200		
S3200 SS=D	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 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 7 residents. The sample included 3 residents. Based on interview and record review the administrator failed to ensure certified staff administered medications according to provider's written order, professional standards of practice, and each manufacturer's recommendations for 1 (#828) of 3 residents. Findings included: - Review of resident # 828's medical record revealed the resident admitted into the facility on 6/29/18 with diagnoses of diabetes, congestive	S3200		

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S3200	Continued From page 10	S3200		

heart failure, reflux disease, hypertension and bipolar disease.

Review of the resident's functional capacity screen dated 6/29/18 revealed the resident needed physical assistance with management of medications and medical treatments. It also revealed the resident had no cognitive deficit and could communicate without difficulties.

Review of the negotiated service agreement dated 6/29/18 revealed the facility will provide physical assistance with medication administration daily as per physician orders. Staff needed to remind resident of time and dose of insulin, put the needle on the pen, prime the pen per manufacturer's instructions, and then dial the dosage. The resident then would self inject the insulin with verbal cues and prompting as needed.

Review of the residents record lacked an assessment to ensure the resident could safely and accurately self-inject his/her insulin.

Review of the physicians orders revealed the following:
6/26/18 - Tylenol Suppository 650 mg - 1 rectally for temp greater than 100.1 every 4 hours as needed. (PRN)
6/27/18 - Discontinue sliding scale insulin (SSI)
8/15/18 - Novolog Flex pen per sliding - Blood sugar 150-199 give 1 unit, 200-249 give 2 units, 250-300 give 3 units, call for blood sugars greater then 300 PRN.

Review of the August 2018 medication administration record lacked the Tylenol suppository order and the Novolog Flex pen sliding scale insulin as ordered by the physician

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S3200	Continued From page 11 for staff to be able to administer. Review of the August medication administration record revealed the resident had 9 blood sugar readings between 150 and 199 which he/she should have received 1 extra unit of insulin and had 2 readings between 200 and 249 and should have received 2 extra units of insulin according to the physicians orders signed on 8/15/18. Observation on 8/28/18 at 9:25 AM certified staff C went to check the residents' blood sugar and dial his/her insulin pen. Upon entering the room staff washed his/her hands and proceeded to check the resident's blood sugar. Staff C then got the Novolog Flex-pen and put a needle on the end, dialed it to 10 units. Staff C handed the resident an alcohol swab to clean area on his/her abdomen, then handed the resident the insulin pen and the resident proceeded to self-inject the 10 units using proper technique. However, Staff C failed to prim the insulin pen with 2 units according to manufactures recommendations prior to the administration of the 10 units. On 8/28/18 at 12:10 PM administrative nursing staff B reported he/she had thought the Tylenol suppository order had been discontinued but could not find the order when reviewed the resident's record. During the same interview administrative staff A reported the sliding insulin scale showed up in the record as being an active order but for some reason it did not show up on the medication administration record. On 8/28/18 at 1: 04 PM administrative nursing staff B reported he/she trained staff to check blood sugars and also to help with self-injection of insulin. Staff B stated staff were trained to prime the pen with 2 units according to manufactures	S3200		

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S3200	Continued From page 12 recommendations and then dial it to the ordered dosage and hand to the resident to inject. Staff B also confirmed the record lacked a self-injection assessment of insulin. The administrator failed to ensure facility staff administered medications according to physicians orders, manufactures recommendations and standards of practice for resident #828.	S3200		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility identified a census of 7 residents. The sample included 3 residents and 5 personnel records reviewed. Based on 2 (administrative nursing staff B and C) of 5 personnel records reviewed and 1 (#289) of 3 resident records	S3310		

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S3310	Continued From page 13 reviewed, the administrator failed to ensure the facility's compliance with the department's Tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Review of resident # 829's record revealed the resident received his/her 1st TB skin test on 7/14/18 and it was read on 7/16/18 with negative results. The information also indicated on 7/23/18 he/she had another TB skin test read which was negative, but the information lacked a date it was initially given, where given, lot # of the vial and the date the vial expired. Review of personnel records on 8/29/18 at 1:00 p.m. with administrator A revealed 2 administrative nursing staff B and D lacked a two-step TB skin test. Administrative staff B hired on 2/20/18 lacked a two-step TB skin test and administrative staff D hired on 7/19/18 lacked a two-step TB skin test. Interview on 8/28/18 with administrator A stated and confirmed administrative nursing staff B and D personnel records lacked a two-step TB skin test. For resident #289 and 2 administrative nursing staff B and D, the administrator failed to ensure the facility's compliance with the department's Tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		