STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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 a resurvey at the above named assisted living facility conducted on 8/8,9,13/2018.	S 000		
S3025 SS=J	26-41-101 (f) STAFF TREATMENT OF RESIDENTS (f) Staff treatment of residents. Each administrator or operator shall ensure the development and implementation of written policies and procedures that prohibit the abuse, neglect, and exploitation of residents by staff. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 9 residents. The sample included 3 residents. Based on interview and record review the operator failed to ensure a licensed nurse was available and responsive to resident concerns and assessed 2 (#808 and #806) of 3 residents. For resident #808 who had complaints of pain, vomiting and no bowel movement for 4 days on 3/13/18. The following day, the licensed nurse failed to assess the resident and consult with the resident's physician before recommending an increase in medication. The licensed nurse further failed to respond to a call from certified staff on 3/15/18 reporting resident now had a heart rate of 154 beats per minute and had not had a bowel movement for 6 days; the licensed nurse failed to assess the resident or document consultation with the physician. Four days later, the resident's family	S3025		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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
S3025	Continued From page 1	S3025		

took the resident to the hospital due to severe pain, shortness of breath and lack of a bowel movement for 10 days. These failures placed resident #808 in immediate jeopardy for harm, injury or death.

Findings included:

- Review of resident #808's medical record revealed he/she admitted to the facility on 11/30/2005 with diagnosis of macular degeneration, mitral valve prolapse, hiatal hernia, osteoporosis, and osteoarthritis.

Review of the functional capacity screen dated 2/26/17 revealed the resident was independent in all ADLs (activities of daily living), including toileting and medication administration.

Review of the negotiated service agreement dated 2/25/17 revealed the resident received basic health care services which included reminders to take his/her medications and 24 hour professional nurse availability.

The health service plan last reviewed on 7/5/17 identified the resident continued to administer his/her own medications, was continent of bowel and bladder and independent in mobility.

The record included a change in condition form dated 6/8/18 which identified the resident had a change in 2 or more ADLs and a change in medical condition. It identified the resident had been hospitalized since 3/19/18 with fracture to hip, increased pain, and bowel obstruction.

Review of the nurses noted revealed the following:
3/13/18 at 9:40 AM certified staff D documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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
S3025	Continued From page 2	S3025		

the resident vomited his/her breakfast and had not had a bowel movement since 3/9/18 (4 days). License nurse A notified.
The record lacked follow up regarding assessment or actions taken by the nurse.

3/14/18 at 10:00 AM certified staff D documented resident reported he/she vomited part of his/her breakfast and still had not had a bowel movement. Certified staff D charted the resident takes 45 ml. of milk of magnesia and yesterday licensed nursing staff A told staff D to have resident take 60 ml of milk of magnesia.
The record lacked documentation of consultation by the nurse with the resident's medical care provider regarding recommended dose in medication and lacked documentation of nursing assessment or follow up.

3/15/18 at 3:30 AM certified staff E noted the resident called feeling heart palpitations and shortness of breath. Staff E checked oxygen saturation and it was 95%, the residents heart rate was 114 beats per minute. The resident refused to use the ambulance or have staff call the nurse. Staff E told the resident to call if he/she needed anything.

3/15/18 at 4:40 AM staff E noted the residents family called and asked staff to check the resident's oxygen and blood pressure since the resident still had heart palpitations and shortness of breath. Blood pressure 164/76, heart rate 154 beats per minute, oxygen was 95%. The resident continued to refuse to use the ambulance and staff E stated he/she would call the nurse on-call. Staff called the nurse and it went directly to voice mail. Staff E told the resident and the daughter he/she would call again later just so he/she was aware of the situation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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
S3025	Continued From page 3 The record lacked documentation of nursing assessment or follow up and lacked an ongoing assessment of the resident's condition 3/19/18 at 10:30 AM licensed nursing staff B noted the resident's family took the resident to the emergency because he/she complained of severe pain and the resident was admitted to the hospital. Review of the hospital emergency room record dated 3/19/18 revealed the resident arrived with complaints of increased lower pelvic pain and it had gotten worse. The resident was diagnosed with a left sided pelvic fracture after having a fall and had not had a bowel movement since then. An x-ray of the resident's abdomen and pelvis were taken which revealed a large amount of stool in the descending colon and no new pelvic fractures. Admitted to the hospital for pain control and constipation reversal. Review of the hospital discharge note dated 7/2/18 revealed the resident had fractured his/her pelvis in 4 places and was admitted to the hospital with severe pain. His/her hospital course was complicated by acute intestinal obstruction which eventually had to be operated on for a partial small bowel resection. During an interview on 8/9/19 at 12:53 PM the resident reported he/she did not remember everything about what happened because she was in so much pain. He/she stated he/she ended up going to the hospital because the pain got so bad and they kept giving her pain medication in the hospital. The medicine causes her to get really confused and so once they got her off the pain medicine the hospital found out it	S3025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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
S3025	Continued From page 4	S3025		

was not her pelvic fractures causing the pain but her intestines. The resident stated he/she could not have a bowel movement and that caused her the pain. He/she said his/her family consulted a surgeon and they repaired the twist in his/her small bowel.

During an interview on 8/8/18 at 8:53 AM administrative nursing staff B reviewed the resident's nurses notes and reported a nurse should have assessed the resident on 3/15/18. Staff B stated he/she did not remember getting any calls about the resident having heart palpitations, shortness of breath or inability to have a bowel movement.

During an interview on 8/9/18 at 9:35 AM administrative staff C reported administrative nursing staff B was on call at night unless he/she was out of town and then either licensed nursing staff A or licensed nursing staff F was on call. Staff C reported nursing staff A was on call usually during the day and if needed, nursing staff F covered the nights.

During an interview on 8/9/18 at 10:38 AM licensed nursing staff A reported he/she did not receive a text or call from staff on 3/15/18. Staff A stated he/she would not have been on call at that time of day, 3:00 - 5:00 AM, and he/she turned off the ringer on his/her phone at night because he/she did not take call at night.

During an interview on 8/9/18 at 11:10 AM administrative staff C reported according to the on-call pay record licensed nursing staff A was on-call on 3/15/18 for the whole 24 hour period.

During an interview on 8/9/18 at 12:43 PM certified staff G reported if he/she needed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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
S3025	Continued From page 5	S3025		

contact the nurse and could not get ahold of them, he/she would just go down the list until he/she got ahold of someone.

Review of the job description for certified staff revealed staff needed to report any significant any significant change in the resident to the director of nursing immediately for further assessment. Report all occurrences to administrator or director of nursing.

For resident #808 the operator failed to ensure a licensed nurse was available and responsive to resident concerns and assessed the residents who had complaints of pain, vomiting and no bowel movement for 4 days on 3/13/18. The following day, the licensed nurse failed to assess the resident and consult with the resident's physician before recommending an increase in medication. The licensed nurse further failed to respond to a call from certified staff on 3/15/18 reporting resident now had a heart rate of 154 beats per minute and had not had a bowel movement for 6 days and failed to assess the resident or document consultation with the physician. Four days later, the resident's family took the resident to the hospital due to severe pain, shortness of breath and lack of a bowel movement for 10 days. These failures placed resident #808 in immediate jeopardy for harm, injury or death.

The jeopardy was removed when the resident was taken to the hospital on 3/19/18.

- Review of resident # 806's record revealed he/she admitted to the facility on 10/6/16 with a diagnosis of Anemia, atrial-fibrillation, peripheral vascular disease, hyperlipidemia and history of right hip fracture.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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
S3025	Continued From page 6 Review of the functional capacity screen dated 10/7/17 revealed the resident needed supervision with bathing, physical assistance with management of medications and treatments and was incontinent of bladder. Review of the negotiated service agreement dated 10/1/17 revealed the resident received basic services which included management of medications, and 24 hour professional nurse availability. Review of the nurses notes revealed the following: 11/6/17 at 9:30 AM certified staff D documented resident complained of not feeling well, he/she coughing. On call nurse A notified. Resident has appointment with physician at 1:30 PM. The record lacked documentation of nursing assessment or follow up and lacked an ongoing assessment of the resident's condition 11/14/17 at 8:00 AM Resident still not feeling well, licensed nursing staff A on call and notified. The record lacked documentation of nursing assessment or follow up and lacked an ongoing assessment of the resident's condition 7/11/18 at 3:00 PM certified staff D documented the resident had some confusion and notified the on call nurse, licensed nurse A. The record lacked documentation of nursing assessment or follow up and lacked an ongoing assessment of the resident's condition. Review of the job description for certified staff	S3025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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
S3025	Continued From page 7 revealed staff needed to report any significant any significant change in the resident to the director of nursing immediately for further assessment. Report all occurrences to administrator or director of nursing. The operator failed to ensure licensed nursing staff was available and responsive to resident concerns.	S3025		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c)(1)(2) The facility reported a census of 9 residents. The sample included 3 residents. Based on interview and record review the operator failed to ensure designated staff completed a functional capacity screen at least once every 365 days and following any significant change in condition for 1 (#808) of 3 residents. Findings included:	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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
S3081	Continued From page 8 - - Review of resident #808's medical record revealed he/she admitted to the facility on 11/30/2005 with diagnosis of macular degeneration, mitral valve prolapse, hiatal hernia, osteoporosis, and osteoarthritis. Review of the functional capacity screen dated 2/26/17 revealed the resident was independent in all ADLs (activities of daily living), including toileting and medication administration. The record lacked evidence of completion additional functional capacity screening after 2/26/2017. During an interview on 8/9/18 at 8:42 AM administrative nursing staff B reported there should have been an annual functional capacity screen completed in February of 2018 and another completed when he/she had a change in condition. The operator failed to ensure designated staff completed a functional capacity screen according to regulations.	S3081		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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
S3092	Continued From page 9 (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR-26-41-202(d)(2) The facility reported a census of 9 residents. The sample included 3 residents. Based on interview and record review the administrator failed to ensure designated staff reviewed, and revised 1(#808) of 3 residents negotiated service agreement at least every 365 days and following any significant change in condition. Findings included: - Review of resident #808's medical record revealed he/she admitted to the facility on 11/30/2005 with diagnosis of macular degeneration, mitral valve prolapse, hiatal hernia, osteoporosis, and osteoarthritis. Review of the functional capacity screen dated 2/26/17 revealed the resident was independent in all ADLs (activities of daily living), including toileting and medication administration. Review of the negotiated service agreement dated 2/25/17 revealed the resident received basic health care services which included reminders to take his/her medications. The resident did not receive ADL services. Review of the amended service agreement dated 1/1/18 revealed the residents services would	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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
S3092	Continued From page 10 remain the same but would have an increase in rent. Review of the resident's record included a change in condition dated 6/8/18 identifying the resident had a change in 2 or more ADLs and a change in medical condition. It revealed the resident had been hospitalized since 3-19-18 with a hip fracture, increased pain and bowel obstruction. Family will stay with the resident for a few weeks to help with private care. Resident needs assistance at this time with ambulating, dressing and bathing. Review of the record lacked review/revision of the negotiated service agreement based upon the resident's change in condition. The administrator failed to ensure designated staff reviewed and revised resident #808's negotiated service agreement after staff identified a significant change in status.	S3092		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage 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	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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
S3175	Continued From page 11 significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 9 residents. Based on interview and record review the operator failed to ensure designated staff completed a self-administration of medication assessment when the resident experienced a significant change of condition, and annually for 1(#808) of 3 residents. Findings included: - - Review of resident #808's medical record revealed he/she admitted to the facility on 11/30/2005 with diagnosis of macular degeneration, mitral valve prolapse, hiatal hernia, osteoporosis, and osteoarthritis. Review of the functional capacity screen dated 2/26/17 revealed the resident was independent in all ADLs (activities of daily living), including toileting and medication administration. Review of the negotiated service agreement dated 2/25/17 revealed the resident received basic health care services which included reminders to take his/her medications. The resident did not receive ADL services. Review of the amended service agreement dated 1/1/18 revealed the residents services would	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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
S3175	Continued From page 12 remain the same but would have an increase in rent. Review of the resident's record included a change in condition dated 6/8/18 identifying the resident had a change in 2 or more ADLs and a change in medical condition. It revealed the resident had been hospitalized since 3-19-18 with a hip fracture, increased pain and bowel obstruction. Family will stay with the resident for a few weeks to help with private care. Resident needs assistance at this time with ambulating, dressing and bathing. Review of the residents record included a self administration assessment tool dated 1/19/15. The record lacked evidence of annual self-administration assessments or when the resident had a significant change on 6/8/18. During an interview on 8/9/18 at 9:35 AM administrative staff C reported staff had only been doing the self-administration assessments on admission. The operator failed to ensure designated staff completed self-administration of medication assessments annually and upon significant change.	S3175		
S3215 SS=F	26-41-205 (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.	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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
S3215	Continued From page 13 (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility 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 facility. (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 26-41-205(h)(1) The facility reported a census of 83 residents. Based on observation, interview and record review the operator failed to ensure designated staff stored Tubersol and Tramadol according to professional standards. Findings included:	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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
S3215	Continued From page 14 - During initial tour on 8/8/18 at approximately 8:00 AM observation of the small refrigerator in the nurses station revealed a vial of Tubersol solution that had been half used without a date as to when the vial had been opened in order for staff to know when to discard it. Review of package insert of the Tubersol package directions noted a vial of Tubersol which had been entered and in use for 30 days should be discarded. During an interview on 8/9/18 at 8:45 AM administrative nursing staff B reported he/she should have dated the vial of Tubersol. The operator failed to ensure designated staff stored Tubersol solution according to standards of practice. - During an interview on 8/8/18 at 9:26 AM administrative staff C reported 1 resident received the medication Tramadol (a narcotic medication) and staff kept the medication in the locked medication cabinet but not double locked and did not count it. During an interview on 8/9/18 at 8:45 AM administrative nursing staff B reported the Tramadol should have been double locked and counted as a narcotic. The operator failed to ensure designated staff stored narcotic medications according to standards of practice.	S3215		