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ALDERBROOK VILLAGE LLC	402 WINDSOR ROAD ARKANSAS CITY, KS 67005

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with investigation of complaints #115371, #119360, #124270, and #131841 of the above assisted living facility on 7/31/18, 8/1/18, 8/2/18, 8/6/18, and 8/8/18.	S 000		
S 225 SS=D	26-39-102 (a) Admission Policy (a) Each licensee, administrator, or operator shall develop written admission policies regarding the admission of residents. The admission policy shall meet the following requirements: (1) The administrator or operator shall ensure the admission of only those individuals whose physical, mental, and psychosocial needs can be met within the accommodations and services available in the adult care home. (A) Each resident in a nursing facility or nursing facility for mental health shall be admitted under the care of a physician licensed to practice in Kansas. (B) The administrator or operator shall ensure that no children under the age of 16 are admitted to the adult care home. (C) The administrator or operator shall allow the admission of an individual in need of specialized services for mental illness to the adult care home only if accommodations and treatment that will assist that individual to achieve and maintain the highest practicable level of physical, mental, and psychosocial functioning are available. (2) Before admission, the administrator or operator, or the designee, shall inform the prospective resident or the resident ' s legal representative in writing of the rates and charges for the adult care home's services and of the resident's obligations regarding payment. This information shall include the refund policy of the adult care home.(3) At the time of admission, the	S 225		

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

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S 225	Continued From page 1	S 225		

administrator or operator, or the designee, shall execute with the resident or the resident ' s legal representative a written agreement that describes in detail the services and goods the resident will receive and specifies the obligations that the resident has toward the adult care home.
(4) An admission agreement shall not include a general waiver of liability for the health and safety of residents.
(5) Each admission agreement shall be written in clear and unambiguous language and printed clearly in black type that is 12-point type or larger.

This REQUIREMENT is not met as evidenced by:
KAR 26-39-102(a)(2)(3)

The facility reported a census of 31 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1 (#252) of 3 residents sampled, prior to admission operator B failed to inform the prospective resident or the resident's legal representative in writing of the rates and charges for the assisted living facility's services and of the resident's obligations regarding payment that included the refund policy of the facility. At the time of admission, operator B failed to execute with the resident or the resident's legal representative a written agreement that described in detail the services and goods the resident would receive and specified the obligations that the resident had toward the facility.

Findings included:

- Record review for resident #252 revealed an

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S 225	Continued From page 2 admission date of 11/23/16 with diagnoses of Parkinson's disease, hypertension, and anxiety. Review of the resident's admission agreement signed by the resident's responsible party and operator B on 11/23/16 revealed the agreement was specifically for resident's admission to a rehabilitation/skilled nursing center and not this assisted living facility. During an interview at 3:00 p.m. on 8/1/18, operator B stated this was the admission agreement the company used at the time of resident's admission to the assisted living facility. Prior to resident #252's admission to the facility, operator B failed to inform the prospective resident or the resident's legal representative in writing of the rates and charges for the assisted living facility's services and of the resident's obligations regarding payment that included the refund policy of the facility. At the time of admission, operator B failed to execute with the resident or the resident's legal representative a written agreement that described in detail the services and goods the resident would receive and specified the obligations that the resident had toward the facility.	S 225		
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	S3085		

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S3085	Continued From page 3 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 31 residents. The sample included 3 residents and 1 focus review resident. Based on record review, interview, and observation for 2 (#252 and #250) of 3 residents sampled, operator B failed to 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, that included a description of the services the resident would receive; identification of the provider of each service; and identification of each party responsible for payment when outside resources provided a service. Findings included - Record review for resident #252 revealed an admission date of 11/23/16 with diagnoses of Parkinson's disease, hypertension, and anxiety. Functional capacity screen dated 5/17/18	S3085		

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S3085	Continued From page 4	S3085		

indicated resident required physical assistance with dressing and toileting; supervision with transferring, walking, and eating; was unable to perform management of medications and treatments; and was at risk for falls.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 5/17/18 documented facility staff provided assistance when needed with dressing and toileting; supervision when transferring, ambulating, and eating; and management of medications and treatments.

Record contained a medical care provider's signed order dated 7/19/18 to approve resident's request for physical therapy and occupational therapy evaluation and treatment for balance and strengthening of lower extremities. Resident's NSA/HCSP lacked an update to include these services.

During an interview with resident in his/her apartment at 3:17 p.m. on 8/1/18, resident stated he/she received physical therapy and occupational therapy visits 2 times a week. Surveyor observed an oxygen concentrator in apartment. Resident stated he/she used the oxygen at night when sleeping and as needed during the day. Resident's NSA/HCSP did not include oxygen therapy and the provider of the oxygen concentrator, oxygen supplies, and the person responsible for maintaining the equipment.

During an interview at 10:54 a.m. on 8/3/18, licensed nurse C stated resident did receive physical therapy and occupational therapy and stated this service was not added to resident's NSA/HCSP. Licensed nurse C located an admission order for oxygen therapy to keep

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S3085	Continued From page 5	S3085		

oxygen saturation greater than 90%. Licensed nurse C stated resident used a facility owned oxygen concentrator and facility's supply of oxygen tubing and cannula.

Operator B failed to ensure the development of a written NSA resident #252 based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's legal representative, that included a description of the services the resident would receive; identification of the provider of each service; and identification of each party responsible for payment when outside resources provided a service.

- Record review for resident #250 revealed an admission date of 10/31/17 with diagnoses of atrial fibrillation, macular degeneration, and chronic pain.

Functional capacity screen dated 4/21/18 indicated resident was unable to perform management of medications and treatments, required supervision to bathe, was at risk for falls, and experienced impaired vision.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 4/21/18 documented facility staff provided management of medications and treatments and assisted resident in/out of shower.

Record contained an admission order dated 10/31/17 for home health physical therapy and occupational therapy. Resident care notes contained an entry by licensed nurse C dated 11/2/17 that physical therapy evaluation was completed by therapist. NSA/HCSP dated 10/31/17 lacked revision to include the provider of

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S3085	Continued From page 6 therapy services, a description of services, and the party responsible for payment of the services. Resident care notes contained an entry by licensed nurse C date 1/5/18 that a physical therapist came to facility to complete an assessment of resident to start treatment. NSA/HCSP dated 12/1/17 and NSA/HCSP dated 1/16/18 did not contain the therapy services by an outside provider. Licensed nurse C indicated on the resident roster that resident #250 received services from an outside provider. During an interview at 11:34 a.m. on 8/2/18, licensed nurse C stated resident received physical therapy from a home health provider after a hospital stay. Licensed nurse C found the hospital discharge orders dated 5/29/18 that home health would follow. Licensed nurse C stated and confirmed he/she did not revise NSA/HCSP each time therapy initiated and discontinued. Operator B failed to ensure the development of a written NSA resident #250 based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's legal representative, that included a description of the services the resident would receive; identification of the provider of each service; and identification of each party responsible for payment when outside resources provided a service.	S3085		
S3105 SS=D	26-41-202 (j) Negotiated Service Agreement Outside Resource (j) If a resident's negotiated service agreement includes the use of outside resources, the	S3105		

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S3105	Continued From page 7 designated facility staff shall perform the following: (1) Provide the resident, 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, with a list of providers available to provide needed services; (2) assist the resident, if requested, in contacting outside resources for services; and (3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice This REQUIREMENT is not met as evidenced by: KAR 26-41-202(j)(3) The facility reported a census of 31 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1 (#250) of 3 residents sampled, licensed nurse C failed to monitor the services provided by an outside resource. Findings included: - Record review for resident #250 revealed an admission date of 10/31/17 with diagnoses of atrial fibrillation, macular degeneration, and chronic pain. Functional capacity screen dated 4/21/18 indicated resident was unable to perform management of medications and treatments, required supervision to bathe, was at risk for falls, and experienced impaired vision. Negotiated service agreement/health care service	S3105		

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S3105	Continued From page 8 plan dated 4/21/18 documented facility staff provided management of medications and treatments and assisted resident in/out of shower. Licensed nurse C indicated on the resident roster that resident #250 received services from an outside provider. During an interview at 11:34 a.m. on 8/2/18, licensed nurse C stated resident received physical therapy from a home health provider after a hospital stay. Licensed nurse C found the hospital discharge orders dated 5/29/18 that home health would follow. Licensed nurse C stated the name of a home health provider and that resident continued to receive therapy services. Licensed nurse C stated he/she monitored therapy services by meeting with therapist when in building to receive an update on resident's progress and when therapy planned to discharge resident. Licensed nurse C stated he/she had not seen the therapist in the facility for some time and went to call the provider. Licensed nurse C returned and stated resident received therapy from a different provider than he/she thought, and resident had been discharged 6/30/18. Licensed nurse C failed to monitor the services provided to resident #250 by an outside resource.	S3105		
S3155 SS=E	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	S3155		

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S3155	Continued From page 9 agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 31 residents. The sample included 3 residents and 1 focus review resident. Based on record review, interview, and observation for 2 (#250 and #252) of 3 residents sampled, operator B failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #250 revealed an admission date of 10/31/17 with diagnoses of atrial fibrillation, macular degeneration, and chronic pain. Functional capacity screen dated 4/21/18 indicated resident was independent with dressing, toileting, transferring, walking with cane or walker, and eating; required supervision to bathe; unable to perform management of medications and treatments; was at risk for falls; and experienced impaired vision. Negotiated service agreement/health care service plan (NSA/HCSP) dated 4/21/18 documented facility staff assisted resident in and out of shower	S3155		

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for resident's safety; staff to remove throw rugs/cords, and no clutter in pathways; and provided management of medications. The NSA/HCSP lacked interventions to address resident's impaired vision.

Review of the medical care provider's orders revealed resident received coumadin (anticoagulant) therapy for atrial fibrillation with dosage based on results of PT/INR (prothrombin time/international normalized ratio to measure clotting time of blood). Resident's record contained a form signed by resident's medical care provider dated 11/16/17 for home monitoring of PT/INR. The NSA/HCSP lacked the provider of home monitoring of PT/INR.

During an interview with resident in the resident's apartment at 1:29 p.m. on 81/18, surveyor observed a metal rail on one side of resident's bed. Resident stated he/she used the rail to get in and out of bed. Continued the interview with resident and a family member at 4:15 p.m. on 8/1/18. Family member stated he/she tested resident's blood (PT/INR) one time a week by using a home monitor. Family member stated he/she called an assigned phone number to report the test result, and that person reported test result to resident's medical care provider. Medical care provider then notified facility nurse with order to change coumadin dose or keep same dose. Resident confirmed he/she had impaired vision due to macular degeneration making it difficult to read activity schedule and the food menu.

During an interview at 11:34 a.m. on 8/2/18, licensed nurse C stated resident's family member did monitor resident's PT/INR and this was not specified in the resident's NSA/HCSP. Licensed

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S3155	Continued From page 11	S3155		

nurse C stated interventions to address resident's impaired vision of plenty of light, pathway clear, knock on door to room and announce self before entering, inform resident of food items served and location on plate, and make sure resident had eyeglasses on. Licensed nurse confirmed the NSA/HCSP lacked these interventions. Licensed nurse C stated he/she had not assessed the safety of the rail on resident's bed and resident's ability to safely use the rail. Licensed nurse C confirmed the NSA/HCSP lacked a description of resident's use of the rail.

Operator B failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #250 and were in accordance with the functional capacity screening and the negotiated service agreement.

- Record review for resident #252 revealed an admission date of 11/23/16 with diagnoses of Parkinson's disease, hypertension, and anxiety.

Functional capacity screen dated 5/17/18 indicated resident was unable to perform management of medications and treatments.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 5/17/18 documented facility provided management of medications and treatments.

During an interview with resident at 3:17 p.m. on 8/1/18 in the resident's apartment, surveyor observed an oxygen concentrator with oxygen tubing. Resident stated he/she wore oxygen at night when sleeping and if needed during the day and evening when awake.

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S3155	Continued From page 12 Resident's NSA/HCSP lacked a description of service of oxygen therapy, including the provider of the equipment, maintenance of the equipment, and monitoring resident's response to oxygen therapy. During an interview at 10:54 a.m. on 8/2/18, licensed nurse C stated the oxygen concentrator resident used belonged to the facility. Licensed nurse C found an admission order for oxygen to keep oxygen saturation readings greater than 90%. Licensed nurse C, when asked who was responsible for management of oxygen therapy, including supplies, cleaning, and resident use and response to oxygen therapy, stated he/she cleaned the concentrator, supplies were supplies facility had on hand, and resident had a pulse oximeter. Licensed nurse C stated if resident reported a low oxygen saturation reading then staff would measure resident's oxygen saturation. Licensed nurse stated and confirmed resident used the oxygen concentrator when sleeping but hardly ever saw resident use oxygen during the day. Licensed nurse C confirmed and stated the NSA/HCSP lacked a description of monitoring oxygen therapy. Operator B failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #252 and were in accordance with the functional capacity screening and the negotiated service agreement.	S3155		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed	S3165		

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S3165	Continued From page 13 nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility reported a census of 31 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 3(#250, #252, and #253) of 3 residents sampled and 1 (#251) of 1 focus review resident, licensed nurse C failed to ensure the negotiated service agreement specified the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. Findings included: - Record review for resident #250 revealed an admission date of 10/31/17 with diagnoses of atrial fibrillation, macular degeneration, and chronic pain. Functional capacity screen dated 4/21/18 indicated resident was unable to perform management of medications and treatments, required supervision to bathe, was at risk for falls, and experienced impaired vision. Negotiated service agreement/health care service plan dated 4/21/18 documented facility staff provided management of medications and treatments and assisted resident in/out of shower. The negotiated service agreement/health care service plan did not specify the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. - Record review for resident #251 revealed an	S3165		

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S3165	Continued From page 14 admission date of 12/1/17 with diagnoses of type 1 diabetes mellitus, diabetic neuropathy, hypertension, and anxiety. Functional capacity screen dated 6/26/18 indicated resident required physical assistance with medication management. Negotiated service agreement/health care service plan dated 6/26/18 documented staff administered medication to resident and performed blood glucose monitoring. The negotiated service agreement/health care service plan did not specify the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. - Record review for resident #252 revealed an admission date of 11/23/16 with diagnoses of Parkinson's disease, hypertension, and anxiety. Functional capacity screen dated 5/17/18 indicated resident required physical assistance with dressing and toileting; supervision with transferring, walking, 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 5/17/18 documented facility staff provided assistance when needed with dressing and toileting; supervision when transferring, ambulating, and eating; and management of medications and treatments. The negotiated service agreement/health care service plan did not specify the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. - Record review for resident #253 revealed an admission date of 6/28/17 with diagnoses Alzheimer's disease, vertigo, and trigeminal neuralgia. Functional capacity screen dated 5/23/18 indicated resident required supervision when walking and unable to perform	S3165		

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S3165	Continued From page 15 management of medications and treatments. Negotiated service agreement/health care service plan dated 5/23/18 documented staff administered all medications to resident and resident received routine wellness checks. The negotiated service agreement/health care service plan did not specify the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. During an interview at 11:20 a.m. on 8/2/18, licensed nurse C stated and confirmed each resident's negotiated service agreement/health care service plan did not specify the name of the licensed nurse responsible for the supervision and implementation of the health care service plan. Licensed nurse C stated he/she recently was told he/she needed to add this to the negotiated service agreement/health care service plan. For residents #250, #251, #252, and #253, licensed nurse C failed to ensure the negotiated service agreement specified the name of the licensed nurse responsible for the implementation and supervision of the health care service plan.	S3165		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i)	S3171		

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S3171	Continued From page 16 The facility reported a census of 31 residents. The sample included 3 residents and 1 focus review resident. Based on record review, interview, and observation for 1 (#252) of 3 residents sampled, operator B failed to ensure health care services were provided to the resident by qualified staff in accordance with acceptable standards of practice. Findings included: - Record review for resident #252 revealed an admission date of 11/23/16 with diagnoses of Parkinson's disease, hypertension, and anxiety. Functional capacity screen dated 5/17/18 indicated resident was unable to perform management of medications and treatments. Negotiated service agreement/health care service plan dated 5/17/18 documented facility provided management of medications and treatments. During an interview with resident at 3:17 p.m. on 8/1/18 in the resident's apartment, surveyor observed an oxygen concentrator with oxygen tubing. Resident stated he/she wore oxygen at night when sleeping and if needed during the day and evening when awake. Resident #252 confirmed facility staff administered his/her medications and he/she self-administered some over-the-counter medications. Resident stated he/she had a medication to take when blood pressure was elevated and had asked for this medication the previous 3 evenings but was told the medication was unavailable.	S3171		

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During an interview at 10:15 a.m. on 8/2/18, resident explained he/she knew when blood pressure was elevated because his/her voice changed and just did not feel good. Resident stated staff took his/her blood pressure each evening he/she requested the medication to lower his/her blood pressure.

The resident's July 2018 medication administration record (MAR) contained an entry for triam-HCTZ (triamterene-hydrochlorothiazide used to treat high blood pressure and fluid retention) 37.5/25 (milligrams) 1 tablet by mouth once daily if B/P (blood pressure) is over 150/92. Resident's record contained a "Fax physician/healthcare provider order sheet" with licensed nurse C's documentation of "Resident requesting reinstatement of the following medication: Triamter-HCTZ 37.5-25. Previous instructions were 1 PO (by mouth) daily for HTN (hypertension) when B/P > 150/92. Please advise." Medical care provider signed the order on 7/22/18 with fax date-stamp to the facility of 7/23/18. The July 2018 MAR indicated resident's blood pressure to be monitored one time a month. Resident's record lacked documentation that resident requested the medication, if resident received the medication, and resident's blood pressure readings obtained by staff.

During an interview at 10:15 a.m. on 8/2/18, licensed nurse C stated staff did take resident's blood pressure when resident requested blood pressure medication but did not record the readings and resident did not receive the medication because it was not available.

During an interview at 10:54 a.m. on 8/2/18, licensed nurse C found an admission order for oxygen to keep oxygen saturation readings

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S3171	Continued From page 18 greater than 90%. Licensed nurse stated and confirmed resident used the oxygen concentrator when sleeping but hardly ever saw resident use oxygen during the day. Licensed nurse C, when asked for documentation of oxygen administration and pulse oximeter readings to monitor resident's need for and response to oxygen therapy, stated resident had a pulse oximeter and if resident reported a low oxygen saturation reading then staff would measure resident's oxygen saturation. Licensed nurse C confirmed certified staff did not routinely monitor resident's oxygen saturation. Operator B failed to ensure health care services were provided to the resident by qualified staff in accordance with acceptable standards of practice.	S3171		
S3178 SS=D	26-41-205 (a) (3) Self Administration of Medication Documented (3) The resident ' s clinical record shall contain documentation of the assessment and the determination. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(3) The facility reported a census of 31 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1 (#252) of 3 residents sampled,	S3178		

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licensed nurse C failed to document an assessment of the resident's physical, cognitive, and functional ability to safely and accurately self-administer and manage selected medications.

Findings included:

- Record review for resident #252 revealed an admission date of 11/23/16 with diagnoses of Parkinson's disease, hypertension, and anxiety.

Functional capacity screen dated 5/17/18 indicated resident was unable to perform medication management and experienced impaired decision making.

Negotiated service agreement/health care service plan dated 5/17/18 documented "Staff administers all medication. OTC (over-the-counter) in room."

The July 2018 medication administration record documented resident self-administered over-the-counter dietary supplements of Phillips Colon Health, Cognisense, Healing colon, and Ultimate Biona Plus.

During an interview at 3:17 p.m. on 8/1/18, resident #252 confirmed he/she self-administered these over-the-counter supplements.

Resident's record lacked documentation of an assessment by a licensed nurse of resident's physical, cognitive, and functional ability to safely and accurately self-administer and manage selected medications.

During an interview at 10:54 a.m. on 8/2/18, licensed nurse C stated he/she did assess

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S3178	Continued From page 20 resident's ability to self-administer these supplements but did not document the assessment. Licensed nurse C failed to document an assessment of resident #252's physical, cognitive, and functional ability to safely and accurately self-administer and manage selected medications.	S3178		
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 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 31 residents. The sample included 3 residents and 1 focus	S3200		

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S3200	Continued From page 21	S3200		

review resident. Based on record review, interview, and observation for 2 (#251 and #252) of 3 residents sampled, operator B failed to ensure medications were administered to each resident in accordance with a medical care provider's written order, professional standards of practice, and each manufacturer's recommendations.

Findings included:

- Record review for resident #251 revealed an admission date of 12/1/17 with diagnoses of type 1 diabetes mellitus, diabetic neuropathy, hypertension, and anxiety.

Functional capacity screen dated 6/26/18 indicated resident required physical assistance with medication management.

Negotiated service agreement/health care service plan dated 6/26/18 documented staff administered medication to resident and performed blood glucose monitoring.

At 4:14 p.m. on 7/31/18, along with certified staff F, surveyor observed a plastic box on a shelf in the medication room with a resident's last name written with a black marker directly one end of the plastic box. Surveyor observed a Novolog Flex pen insulin pen and a Lantus Solostar insulin pen in the plastic box. Each insulin pen was not labeled to identify the resident to receive and the date the pen was opened. Certified staff F stated these insulin pens belonged to (resident #251) and turned the box around to show surveyor the last name of resident #252 that was different than the resident's name on the other end of the plastic box. Certified staff F stated certified medication aides prepared and dialed the pen for

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resident to self-inject insulin.

The August 2018 medication administration record documented resident received Novolog insulin 25 units subcutaneously 3 times a day with meals and Lantus insulin 40 units subcutaneously at bedtime.

Manufacturer of Novolog flex pen recommends not using the insulin 28 days after opening. Manufacturer of Lantus Solostar pen recommends not using the insulin pen 28 days after opening.

During an interview at 11:59 a.m. on 8/2/18, licensed nurse C stated certified staff were to label insulin pens when opened with the resident's name and the date opened.

Operator B failed to ensure medications were administered to resident #251 in accordance with professional standards of practice and each manufacturer's recommendations.

- Record review for resident #252 revealed an admission date of 11/23/16 with diagnoses of Parkinson's disease, hypertension, and anxiety.

Functional capacity screen dated 5/17/18 indicated resident was unable to perform medication management and experienced impaired decision making.

Negotiated service agreement/health care service plan dated 5/17/18 documented "Staff administers all medication. OTC (over-the-counter) in room."

During an interview at 3:17 p.m. on 8/1/18, resident #252 stated he/she had a medication to

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take when blood pressure was elevated and had asked for this medication the previous 3 evenings but was told the medication was unavailable. At 10:15 a.m. on 8/2/18 resident #252 stated staff took his/her blood pressure each evening he/she requested the medication.

The resident's July 2018 medication administration record contained an entry for triam-HCTZ (triamterene-hydrochlorothiazide used to treat high blood pressure and fluid retention) 37.5/25 (milligrams) 1 tablet by mouth once daily if B/P (blood pressure) is over 150/92. Resident's record contained a "Fax physician/healthcare provider order sheet" with licensed nurse C's documentation of "Resident requesting reinstatement of the following medication: Triamter-HCTZ 37.5-25. Previous instructions were 1 PO (by mouth) daily for HTN (hypertension) when B/P > 150/92. Please advise." Medical care provider signed the order on 7/22/18 with fax date-stamp to the facility of 7/23/18. Resident's record lacked documentation that resident requested the medication and resident's blood pressure readings obtained by staff.

At 9:51 a.m. on 8/2/18, surveyor asked certified staff G if triamterene-hydrochlorothiazide was available for the resident. Certified staff G stated the medication was delivered from the pharmacy on 8/1/18.

During an interview at 10:10 a.m. on 8/2/18, licensed nurse C stated as soon as the signed order received, (certified staff G) faxed the order to the pharmacy, likely on 7/23/18. Licensed nurse C was unable to provide a fax confirmation. Licensed nurse C stated that on Sunday (7/29/18) he/she discovered the medication was not

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S3200	Continued From page 24 available, so he/she faxed the order to the pharmacy again. Licensed nurse C stated the medication was not received from the pharmacy, so he/she called the pharmacy on 8/1/18 and medication was delivered on that day. Phone interview at 10:43 a.m. on 8/2/18, pharmacy tech H stated there were no records of a fax received from the facility for the medication and medication was not filled until 8/1/18. At 10:45 a.m. on 8/2/18, certified staff G removed the medication from the medication cart and surveyor observed pharmacy label with fill date of 8/1/18. Operator B failed to ensure a medication was administered to resident #252 in accordance with a medical care provider's written order	S3200		
S3247 SS=F	26-41-102 (c) Staff Qualifications RN available (c) A registered professional nurse shall be available to provide supervision to licensed practice nurses, pursuant to K.S.A. 65-1113 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(c) The facility reported a census of 31 residents. The sample included 3 residents and 1 focus review resident. Based on interview for all residents, operator B failed to ensure a registered professional nurse provided supervision to the licensed practical nurse, pursuant to K.S.A. 65-1113 and amendments thereto.	S3247		

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S3247	Continued From page 25 Findings included: - During an interview at 11:50 a.m. on 7/31/18, operator B stated the facility nurse (licensed nurse C) was a licensed practical nurse. Operator B stated the corporate office was in the process of hiring a registered nurse (RN) to supervise (licensed nurse C) since the previous supervising RN left 3 weeks ago. Operator B stated his/her spouse was an RN and (licensed nurse C) could call the RN with any questions. Operator B confirmed that RN was not an employee of or contracted with the company to supervise the licensed practical nurse. At 12:04 p.m. on 7/31/18, when asked for the name of his/her supervising RN, licensed nurse C stated he/she did not know. Licensed nurse C stated the previous supervising RN (licensed nurse E) had not been available for 2 years. Licensed nurse C stated he/she contacted the operator's spouse with questions but technically was not his/her supervisor. At 12:10 p.m. on 8/2/18, administrative staff D stated (licensed nurse E) supervised the licensed practical nurse. Administrative staff D stated the name of another RN and the name of the operator's spouse as registered nurses the licensed practical nurse could contact questions. Surveyor informed administrative staff D that licensed nurse C stated there was not an RN to supervise him/her. Surveyor asked administrative staff D to provide the date an RN was in the building or available to supervise licensed nurse C. At 12:33 p.m. on 8/2/18, administrative staff D stated 9/29/16 as the last date RN (licensed nurse E) was in the facility.	S3247		

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S3247	Continued From page 26 For all residents, operator B failed to ensure a registered professional nurse provided supervision to the licensed practical nurse, pursuant to K.S.A. 65-1113 and amendments thereto.	S3247		
S3261 SS=E	26-41-105 (f) (11) Resident Record 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 26-41-105(f)(11) The facility reported a census of 31 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 2 (#250 and #252) of 3 residents sampled, licensed nurse C failed to ensure each resident's record contained 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. Findings included: - Resident roster documented resident #250 experienced a fall in the last 180 days. Record review for resident #250 revealed an	S3261		

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admission date of 10/31/17 with diagnoses of atrial fibrillation, macular degeneration, and chronic pain.

Functional capacity screen dated 4/21/18 indicated resident was independent with dressing, toileting, transferring, and walking; experienced impaired vision; did not experience impaired cognition; and was at risk for falls.

Negotiated service agreement/health care service plan dated 4/21/18 documented interventions to address resident's risk for falls as remove throw rugs, cords, and no clutter in pathway.

Resident's record lacked documentation that resident experienced a fall in the last 180 days.

During an interview at 11:34 a.m. on 8/2/18, licensed nurse C stated resident had fallen since returning from hospital on 5/29/18 but unsure of the exact date and confirmed he/she did not document the incident in the resident's record. Licensed nurse C stated a staff member went to resident's room to walk resident to lunch and found resident on bathroom floor. Licensed nurse stated resident was uninjured.

Licensed nurse C failed to ensure resident #250's record contained documentation of an incident including the date, time of occurrence, action taken, and results of the action.

- Record review for resident #252 revealed an admission date of 11/23/16 with diagnoses of Parkinson's disease, hypertension, and anxiety.

Functional capacity screen dated 5/17/18 indicated resident required physical assistance with dressing and toileting; supervision with

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transferring, walking, 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 5/17/18 documented facility staff provided assistance when needed with dressing and toileting; supervision when transferring, ambulating, and eating; and management of medications and treatments.

During an interview with resident in his/her apartment at 3:17 p.m. on 8/1/18, resident stated he/she had a medical care provider's order for a medication he/she could be given when blood pressure increased. Resident stated he/she asked for the medication 3 evenings in the last week but was told the medication had not been delivered from the pharmacy.

The resident's record lacked documentation that resident requested a medication for elevated blood pressure and lacked documentation of resident's blood pressure readings.

Interview with resident at 10:15 a.m. on 8/2/18, resident described his/her symptoms of voice changed and just did not feel good and knew that was when blood pressure was elevated. Resident stated he she asked for blood pressure medication the last 3 evenings, staff did take his/her blood pressure, but medication was unavailable.

During an interview at 10:52 a.m. on 8/2/18, licensed nurse C confirmed resident's record lacked documentation of resident's report of symptoms and request for medication as needed for elevated blood pressure including blood pressure readings,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N018010	A. BUILDING: _____ B. WING _____	08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERBROOK VILLAGE LLC	402 WINDSOR ROAD ARKANSAS CITY, KS 67005

(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
S3261	Continued From page 29 Licensed nurse C failed to ensure resident #252's record contained documentation of all symptoms and other indications of illness including the date, time of occurrence, action taken, and results of the action.	S3261		