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{S 000}	INITIAL COMMENTS	{S 000}		
{S3015} SS=F	26-41-101 (c) Administration Position Description (c) Administrator and operator position description. Each licensee shall adopt a written position description for the administrator or operator that includes responsibilities for the following: (1) Planning, organizing, and directing the facility; (2) implementing operational policies and procedures for the facility; and(3) authorizing, in writing, a responsible employee who is 18 years old or older to act on the administrator ' s or operator's behalf in the absence of the administrator or operator. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(c) The census equalled five the sample included three Residents. Based on observation and interview, for all Residents, Residents' family members, Residents' legal representatives, and employees of facility, the licensee failed to adopt operational policies and procedures for the facility that authorized in writing a responsible employee to act on the administrator's behalf in the absence of the administrator. Findings included: - Review of assignment information identified "Operator of facility" as administrator #D. Upon entrance to facility on 6/20/18 at 4:15pm,	{S3015}		

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

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{S3015}	Continued From page 1 Medical Records staff #E stated administrator #D is the "Operator" of the Assisted Living... he/she is out of facility for the day... he/she just left... By observations in facility 6/20/18 and 6/21/18, no posting located with designation of employee in charge in the absence of administrator #D. On 6/21/18 at 1:35pm, Administrator #D stated we have a written policy regarding who is in charge... it does not specify an individual but specifies a position considered in charge when I am not here... By review on 6/21/18 at 2:10pm, the policy and procedure identified a position but failed to identify an individual to be in charge in the absence of the Administrator. For all Residents, employees, visitors, and family members, the licensee failed to adopt operational policies and procedures for the facility that authorized in writing a responsible employee to act on the administrator's behalf in the absence of the administrator.	{S3015}		
{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	{S3085}		

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{S3085}	Continued From page 2 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) The census equalled five the sample included three Residents. Based on observations, interviews, and reviews of records, for two of three sampled (#1089 and #1078), the Administrator failed to ensure the negotiated service agreement (NSA) included a description of services the Resident would receive, and identification of each party responsible for payment if outside resources provide a service. Findings included: - Review of record revealed #1089 admitted to facility 5/11/12 with diagnoses of anxiety, depressive disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, gastroesophageal reflux disease, anemia, and osteoarthritis. Current functional capacity screen of 5/04/18 assessed #1089 in need of physical assistance with bathing and treatments; in need of supervision with dressing, toileting, and medication management; with occasional incontinence, decision making impairment, falls and unsteadiness, used a walker, wheelchair,	{S3085}		

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{S3085}	Continued From page 3 and electric scooter. Current NSA of 5/04/18 documented #1089 to receive assistance with bathing; assistance with dressing as needed; daily emptying of bedside urinal. The NSA documented staff to administer all medications, and also "Resident may self medicate or keep at bedside." The NSA lacked the medications self administered by the Resident The NSA lacked the provider of oxygen, and lacked the payment source of the oxygen. The NSA documented "lab draws as ordered" but failed to identify what lab tests, how often, or who completed the lab draws, and if an outside provider, the payment source. The NSA failed to identify the source of transportation, with all options - family/facility, and physician appointments/activities, shopping all left blank. On 6/21/18 at 2:36pm, director of nursing #F stated I have not re-done these... confirmed the NSA still lacked a description of services for lab testing, self administered medications, transportation, provider name and payment source for oxygen... The Administrator failed to ensure the development of an NSA which included a description of services #1089 to receive, the provider of oxygen and lab draws, and the payment source for these services. - Review of record revealed #1078 admitted to facility 5/03/18 with diagnoses of edema, chronic atrial fibrillation, change in skin texture, and	{S3085}		

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{S3085}	Continued From page 4 anticoagulation. Current functional capacity screen of 5/04/18 assessed #1078 in need of physical assistance with medications and treatments, in need of supervision with bathing, with decision making impairments. Current NSA of 5/03/18 documented #1078 to receive bathing assistance as requested, facility to administer all medications and apply all topicals. Physician's order of 5/03/18 directed the use of Oxygen at 2 LPM (liters per minute) per nasal cannula nightly. The NSA lacked the use of oxygen, lacked the name of the provider of the oxygen, and lacked the payment source for the oxygen. On 6/21/18 at 2:52pm, director of nursing #F confirmed the NSA lacked oxygen, the provider, and payment source... stated I know what needs to happen with these but haven't had time... The Administrator failed to ensure the development of an NSA which included a description of services #1078 to receive, the provider of oxygen, and the payment source for this service.	{S3085}		
{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	{S3200}		

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{S3200}	Continued From page 5 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)(1-2) The census equalled five the sample included three Residents. The Resident Roster identified all Residents with facility managed medications and three who self administered select medications. Based on interview and reviews of records, for two of three sampled Residents (#1078 and #1082), the Administrator failed to ensure all medications and biological's administered to each Resident in accordance with professional standards, and in accordance with written medical care provider orders. Findings included: - Review of record revealed #1078 admitted to facility 5/03/18 with diagnoses of edema, chronic atrial fibrillation, change in skin texture, and anticoagulation. Current functional capacity screen of 5/04/18 assessed #1078 in need of physical assistance	{S3200}		

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{S3200}	Continued From page 6 with medications and treatments. Current NSA of 5/03/18 documented #1078 to receive medication and treatment management by facility. Comparison of the June 2018 MAR (medication administration record) with current signed physician's orders revealed discrepancies. Signed physician's orders dated 6/07/18 contained the following medications. These medications not included on the current MAR, and no written orders located to discontinue them: Cozaar (blood pressure) 50mg (milligrams) one tablet by mouth once a morning Diclofenac (non-steroidal anti inflammatory) 50mg tablet twice daily Losartan-hydrochlorothiazide (blood pressure) 50-12.5mg Misoprostol (ulcers) 200mcg (micrograms) twice a day - Review of record revealed #1082 admitted to facility 4/20/18 with diagnoses of tachycardia, history of falling, leukemia, arteritis, insomnia, hypertension, and osteoporosis. Current functional capacity screen of 7/07/17 assessed #1082 unable to perform medication and treatment management. Current NSA of 7/07/18 documented #1082 to receive medication and treatment management by facility. Comparison of the June 2018 MAR (medication administration record) with current signed physician's orders revealed discrepancies.	{S3200}		

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{S3200}	Continued From page 7 Signed physician's orders dated 5/14/18 contained an order for colace (stool softener) 100mg one capsule once a morning. This order not on the current MAR and no written order located to discontinue the colace. On 6/21/18 at 2:52pm, director of nursing #F confirmed the MAR lacked these orders... stated medical records staff recently changed... medical records will no longer be doing the MAR's... I and another nurse are going to be doing the MAR's... For #1078 and #1082 the Administrator failed to ensure all medications administered in accordance with professional standards of practice and in accordance with written physician's orders.	{S3200}		
{S3201} SS=E	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the	{S3201}		

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{S3201}	Continued From page 8 medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(3) The census equalled five the sample included three Residents. All Residents received medication management by facility and three Residents self administered select medications. Based on observation, interview, and review of record: For one of three sampled (#1082) and for one non-sampled (#1085) with facility managed medications, the Administrator failed to ensure staff remained with the Resident until medication ingested; and For one of two sampled (#1089) who self administered some medications, the Administrator failed to ensure staff administered only the medication that the licensed nurse or medication aide personally prepared. Findings included: - By observations on 6/21/18 at 11:40am, during the noon meal service in the dining room, Registered nurse #P placed a prepared pill cup beside the dinner plates of #1082. Registered nurse #P then returned to the medication cart on the other side of room, with back to tables and Residents as he/she documented in the MAR (medication administration record) on the cart, and then prepared the next dose of medication. Registered nurse #P carried a pill cup to the table for #1085 and also placed this pill cup beside the Resident's dinner plate, returned to the medication cart, and with back facing the tables	{S3201}		

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{S3201}	Continued From page 9	{S3201}		

and Residents documented in the MAR on the medication cart. Registered nurse #P failed to remain with the Residents until the medications were ingested.

On 6/21/18 at 2:10pm Administrator #D provided the facility policy and procedure titled Administering Medications. Administrator #D stated I observed staff passing medications this morning and the staff remained with the Resident until they took the medications... Administrator #D stated the staff passing medications this morning was Registered nurse #P... confirmed the policy and procedure failed to address staff remaining with the Resident until all medication ingested.

The Administrator failed to ensure staff remained with the Residents until medications ingested.

- Review of record revealed #1089 admitted to facility 5/11/12 with diagnoses of anxiety, depressive disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, gastroesophageal reflux disease, anemia, and osteoarthritis.

Current functional capacity screen of 5/04/18 assessed #1089 in need of supervision with medication management and in need of physical assistance with treatment management.

Current NSA of 5/04/18 documented #1089 to receive staff administration of all medications, and also "Resident may self medicate or keep at bedside." The NSA lacked the medications self administered by the Resident.

The May 2018 MAR (medication administration record) documented:

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{S3201}	Continued From page 10 Menthol cough drops (may keep at bedside); Tums (for indigestion, may have at bedside); Symbicort inhaler (for obstructive pulmonary disease, may keep at bedside); Ipratropium bromide spray (for allergic rhinitis, may keep at bedside), and Combivent Respimat (for obstructive pulmonary disease, may keep at bedside). The MAR documented daily facility staff administration of the Symbicort, Combivent, and Ipratropium bromide although identified as self administered. On 6/21/18 at 2:36pm director of nursing #F acknowledged staff initialed doses of medications #1089 self administered... stated we haven't gotten to that yet for correction... I am aware that has to change... For #1089 who self administered some medications, the Administrator failed to ensure staff administered (documented) only the medication that the licensed nurse or medication aide personally prepared.	{S3201}		
{S3214} SS=D	26-41-205 (g) (4) Sample & Indigent Medication Program Meds (g) (4) Licensed nurses and medication aides may administer sample medications and medications from indigent medication programs if the administrator or operator ensures the development of policies and implementation of procedures for receiving and identifying sample medications and medications from indigent medication programs that include all of the following conditions: (A) The medication is not a controlled medication.	{S3214}		

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{S3214}	Continued From page 11 (B) A medical care provider ' s written order accompanies the medication, stating the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration. (C) A licensed nurse or medication aide receives the medication in its original, unbroken manufacturer ' s package. (D) A licensed nurse documents receipt of the medication by entering the resident ' s name and the medication name, strength, and quantity into a log. (E) A licensed nurse places identification information on the medication or package containing the medication that includes the medical care provider ' s name; the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider ' s order. Facility staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches the information on the medical care provider ' s order. (F) A licensed nurse informs the resident or the resident ' s legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies. The resident ' s clinical record shall contain documentation that the resident or the resident ' s legal representative has received the information and accepted the risk of potential adverse consequences.	{S3214}		

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{S3214}	Continued From page 12 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(4) The census equalled five the sample included three Residents. All Residents identified as having facility managed medications, and three self administered select medications. Based on interviews and reviews of records, for one non-sampled Resident who received sample medications (#1085), the Administrator failed to ensure the development of policies and procedures for receiving and identifying sample medications. Findings included: - On 6/21/18 at 4:00pm Administrator #D stated I don't remember seeing a sample medication policy and procedure... nothing new to review for that... - On 6/21/18 at 4:55pm, in medication room of long term care facility, licensed practical nurse #J provided sample medication containers used for #1085. These sample medications included Novolog insulin and Levemir insulin. The medication boxes and vials contained the Resident's name and the physician's name. These medication containers lacked any other labeling or directions from the physician. Licensed practical nurse #J confirmed the packages lacked a physician's order stored with the medications, the dosage, route, frequency and any cautionary instructions... #J confirmed no log available to document the arrival of medication and amount received... and not aware of documented informed consent process completed with the Resident or the Resident's	{S3214}		

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{S3214}	Continued From page 13 representative. Review of record revealed #1085 admitted to facility 9/21/15 with diagnoses of diabetes, dyspepsia, insomnia, hypertension, atrial fibrillation, depressive disorder, anxiety, osteoarthritis, and gastroesophageal reflux disease. The current FCS of medical record dated 9/16/15. This FCS assessed #185 unable to perform medication and treatment management. The MAR (medication administration record) documented staff administration of Novolog, Humalog, Lantus, Toujeo, and Basaglar insulin to #1085. Clinic visit physician dictations reference supply of sample insulin distributed to #185. For #1085 the Administrator failed to ensure the development of policies and procedures for receiving and identifying sample medications as required, to include: documentation of receipt of the medication on a log, identifying information placed on package that matches the written order, and obtaining informed consent from Resident or their representative for use of a medication that did not go through usual pharmacy procedures.	{S3214}		
{S3246} SS=F	26-41-102 (b) Staff Qualification Awake - Responsive (b) Direct care staff or licensed nursing staff shall be awake and responsive at all times. This REQUIREMENT is not met as evidenced by:	{S3246}		

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{S3246}	Continued From page 14 KAR 26-41-102 The census equalled five the sample included three Residents. Based on observations and interviews, for all Residents of the Assisted Living facility (ALF), the Administrator failed to ensure direct care staff responsive at all times. Findings included: - On 6/20/18 during entrance to facility beginning at 4:15pm, medical record staff #K and director of nursing #F reported Administrator #D not in the building at this time. Resident Roster completed by medical record staff #K. By observation at 4:20pm, door between ALF and Long Term Care (LTC) unit closed, with digital key pad code required to enter from LTC side, and a button on wall to press to enter from the ALF side. On 6/20/18 at 4:45pm activities staff #Q stated I am over in the ALF area until 8:00pm... come back over here put stuff away... pass ice and water, then home at 9:30pm... no one stays over there (in ALF) all the time... usually someone over there during the day until 6:00pm... we play dominoes in the evening... By review, staff schedule posted on the wall in the ALF recorded daily shifts ending at 6:00pm on most dates of June 2018, and on some dates ending at "supper." On 6/21/18 at 1:35pm administrator #D confirmed the ALF still not covered by staff 24/7... confirmed help wanted ads in place to supplement available staff for the unit. Observations 6/21/18 revealed licensed practical	{S3246}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	R 07/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

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{S3246}	Continued From page 15 nurse #L on duty in the ALF, and periodically leaving the unit to complete tasks with the ALF not attended by staff. The following times no staff noted to be present in the ALF: 11:28am to 11:34am 12:17pm to 12:23pm 12:57pm to 1:01pm 1:06pm to 1:08pm 1:20pm to 1:29pm 1:47pm to 4:00pm For all Residents of facility, the Administrator failed to ensure direct care staff present in unit and responsive to Residents' needs at all times.	{S3246}		