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	N088003	A. BUILDING: _____ B. WING _____	03/14/2018

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BROOKDALE LIBERAL SPRINGS	1500 N TERRACE LIBERAL, KS 67901

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with a complaint survey (#114496, #122540, and #124574) at the above named assisted living facility conducted on 3/12,13,14/2018.	S 000		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S3028		

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

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f)(3) The facility reported a census of 42 residents. The sample include 3 residents and 3 focused resident reviews. Based on interview and record review the operator failed to ensure each allegation of potential abuse, neglect, or exploitation was reported to the Kansas Department for Aging and Disabilities within 24 hours for 1 (# 314) of 3 residents reviewed for falls. Findings included: - Review of resident #314's record revealed he/she admitted to the facility on 5/26/17 with diagnoses of dementia, colon cancer, anemia, hyperlipidemia, and hypertension. Review of the resident's Functional capacity screen dated 6/19/17 revealed the resident needed physical assistance of staff with all activities of daily living (ADLs) except for eating. He/she did not have problems with falls/unsteadiness but had cognitive deficits. Review of the resident's FCS dated 12/6/17 revealed no change in the residents functionality except he/she did have falls/unsteadiness. Review of the resident's negotiated service agreement/health service plan (NSA/HSP) dated 7/13/17 revealed the resident needed assistance of staff for ADLs due to the resident being unsafe completing ADLs on his/her own. The resident had falls at home since prior admission to facility required staff assistance for any mobility or transfers. It also had revision the resident fell on	S3028		

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S3028	Continued From page 2	S3028		

9/1/17 due to staff forgot to replace call pendant after whirlpool and staff educated and will do routine hourly checks on the resident. The resident had another fall on 10/28/17 in bathroom when he/she attempter to self transfer. Resident encouraged to ring and wait on assistance of staff.

Review of the NSA/HSP dated 12/6/17 revealed staff needed to continue to provide assistance with ADLs and also included 2 additional falls.

Review of the fall investigation dated 9/1/18 revealed the unwitnessed fall occurred at 8:10 AM and the resident reported he/she had been on the floor "all night". The resident's call pendant had been removed the evening before during his/her whirlpool and did not get replaced before he/she went to bed. The resident reported he/she fell in the living room after getting out of bed and walking a few feet to try and get help. The investigation revealed staff had assisted the resident to the bathroom at 5:00 AM and then back to bed. Staff members were counseled regarding removal of call pendants and not documenting in the log the provision of cares in the resident log.

Review of the fall investigation dated 10/28/17 revealed the resident had a fall at 8:30 AM. Staff found resident on the floor in his/her bathroom when they delivered his/her morning room tray. The resident's call light was not answered timely as staff was in the dining room serving breakfast. The resident stated he/she needed to go to the bathroom so he/she got up to go. The investigation revealed staff needed to check on the resident every 1 1/2 - 2 hours and reminded the resident not to get up without staff assistance.

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S3028	Continued From page 3 Review of the call pendent record for 10/28/17 revealed the resident turned on his/her call light at 8:01 AM and staff answered it at 8:26 AM, 25 minutes after he/she called for help. Review of the employee time clock records revealed staffing for the time of the fall included a CMA and a CNA. Review of the Abuse, Neglect, and Exploitation policy dated 6/10/2011 revealed the definition of "Neglect" as the failure or omission by one's self, caretaker or another person to provide goods or services which are reasonably necessary to ensure safety and well being and to avoid physical or mental harm or illness. The policy also indicated if the determination is made that there is reasonable cause to believe an incident constitutes abuse, neglect or exploitation the executive director or designee should report such information to the KDOA (Kansas department on aging) as soon as practicable. The operator failed to ensure designated staff reported all allegations of abuse, neglect, and exploitation to the Kansas Department for Aging and Disabilities after the 2 mentioned above falls for resident #314.	S3028		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department.	S3080		

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S3080	Continued From page 4 The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: K.A.R.26-41-201(a) The facility reported a census of 42 residents. The sample included all 3 residents and 3 resident focused reviews. Based on interview and record review the operator failed to ensure 1 (#318) of 4 residents had a functional capacity screen (FCS) completed on or before admission to the facility. Findings included: -- Review of resident #318's record revealed he/she admitted to the facility on 2/10/18 with diagnosis of macular degeneration, hypertension, chronic respiratory failure, osteoporosis and dementia. The Functional capacity screen dated 2/12/18 revealed the resident could not manage medications and had short and long-term memory deficit. The FCS had a nurses signature of completion 2/12/18, 2 days after admission. During an interview on 3/13/18 at 5:20 PM administrative nursing staff G reported he/she expected the FCS to be completed on admission to the facility.	S3080		

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S3080	Continued From page 5 Review of the Resident functional capacity screen policy dated 4/2015 revealed a functional capacity screen shall be conducted on each resident on or before admission. The operator failed to ensure designated staff completed the functional capacity screen on or before the time of admission for resident #318.	S3080		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201 (d) The facility reported a census of 42 residents. The sample include 3 residents and 3 focused resident reviews. Based on record review and interview the facility failed to ensure 1 (#313) of 4 residents functional capacity at the time of screening accurately reflected their residents status. Findings included: - Review of resident #313's record revealed he/she admitted to the facility on 5/19/11 with diagnosis of anemia, hypothyroidism, major depressive disorder and epilepsy. Review of the Functional Capacity screen (FCS)	S3082		

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S3082	Continued From page 6 dated 3/3/18 revealed the resident independent with walking an ambulation and did not indicate the resident had falls/unsteadiness. The FCS did not include the fall the resident had on 12/1/17. Review of the residents negotiated service agreement/health service plan dated 3/5/18 revealed the resident was independent with ambulating with a walker, could get self to and from meals and activities. Review of the residents record revealed he/she had a fall on 12/1/17 in his/her room and staff found him/her on the floor in the bathroom. On 3/14/18 at 9:57 AM administrative nursing staff G reported the FCS should identify any fall a resident had within the 180 days. The operator failed to ensure the functional capacity screen accurately identified resident #313's risk for falls.	S3082		
S3166 SS=F	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (a)	S3166		

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S3166	Continued From page 7 The facility reported a census of 42 residents. The sample include 3 residents and 3 focused resident reviews. Based on observation, interview and record review the operator failed to delegate the nursing procedure of blood sugar monitoring and dialing dosages for insulin pens to each certified medication aide (CMA) under the Kansas nurse practice act, K.S.A.65-1124 and amendments thereto. Findings included: Review of employee records revealed certified staff D, E, and F did not have evidence of licensed nurse delegation for blood glucose testing or dialing insulin dosages for an insulin pen. Both of the tasks are not part of the certified medication aide curriculum. Observation on 3/13/18 at 7:20 AM certified staff F dialed the residents Novolog insulin pen to 7, showed another CMA to confirm dose and then went to the residents room. Upon entering the residents room staff F proceeded to check the resident blood sugar after washing his/her hands and putting on gloves. Staff F wiped the residents finger with alcohol pad, put the strip in the glucometer machine, and then used a safety lancet to poke the residents finger. Staff F put a drop of blood on the lancet and then told the resident what the results were. Staff F then double checked the insulin pen, gave it to the resident, and the resident stuck herself with the pen where he/she had wiped it with an alcohol pad. During an interview on 3/12/18 at approximately 1:30 PM Operator A reported the licensed nurse would give the insulin but we have 1 resident who the CMA dialed the dosage amount of insulin to	S3166		

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S3166	Continued From page 8 be administered and the resident self-injected the insulin. Staff A stated the medication aides checked the blood sugars. On 3/13/18 at 4:00 PM operator A reported he/she could not find record of the 3 CMA's having had the nurse delegation completed. Review of the Medication Administration Practical policy dated 9/1/2012 revealed each Certified medication aide and licensed associate are required to learn the proper techniques used to assist residents with medication administration. The policy did not specifically identify the nurse delegation for tasks that were not part of the CMA curriculum. The operator failed to ensure certified medication aides were properly trained and signed off on completion of blood glucose testing and dialing up insulin dosages on an insulin pen which are a nursing procedure.	S3166		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility.	S3200		

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S3200	Continued From page 9 (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 42 residents. The sample include 3 residents and 3 focused resident reviews. Based on interview and record review the operator failed to ensure designated staff completed a self-injection assessment for 1 of 1 (#316) resident that received insulin to ensure he/she self-injected the insulin according to standards of practice and manufacturer's recommendations. Findings included: - Review of resident #316's medical record revealed the resident admitted to the facility on 8/8/16 with diagnoses of hypertension and type 2 diabetes. The functional capacity screen dated 12/1/17 revealed the resident could not manage his/her medications and treatments and had both short and long-term memory deficit. The negotiated service agreement/health service plan dated 12/4/17 revealed the resident required staff assistance to administer all medications. He/she needed staff to assist with checking blood sugars and dialing the appropriate dosage of insulin 4 times a day. The resident self-injected the insulin with staff supervision.	S3200		

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S3200	Continued From page 10 Review of the record lacked evidence designated staff completed an assessment to ensure the resident could self-inject his/her insulin. On 3/13/18 at 10:00 AM licensed nursing staff B reported the assessment should be under the assessment tab and if it was not there he/she did not know where it would be. On 3/13/18 at 10:45 AM administrative nursing staff G looked in the resident's chart and confirmed the self-injection assessment was not in the record. Review of the self-administration policy dated 10/2015 revealed residents who desire to self-administer medications should be permitted to do so if the admitting physician verifies it is appropriate, the nurse confirmed the resident's abilities, and any applicable state requirements are met. The operator failed to ensure delegated staff completed a self-injection assessment for resident #316 according to standards of practice and manufacturer's recommendations.	S3200		
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. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals	S3215		

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S3215	Continued From page 11 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)(4) The facility reported a census of 42 residents. The sample include 3 residents and 3 focused resident reviews. Based on observation, interview, and record review the operator failed to ensure all medications including a vial of Tubersol (Tuberculin purified protein derivative -PPD) for testing of Tuberculosis (TB) were stored in accordance to manufactures recommendations and not administered beyond the manufacturer's recommended date of expiration	S3215		

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S3215	Continued From page 12 Findings included: During initial tour of the facility observations of the medication room revealed an open vial of Tubersol with an open date of 2/1/18. The vial had very little left in it. During an interview on 3/12/18 at 12:00 PM licensed nursing staff B reported the vial was only good for 30 days after opening. Staff B took the vial and discarded it. During an interview on 3/14/18 at 9:10 AM licensed nursing staff B reported certified staff H and I received the PPD skin test on 3/7/18. Seven days after the vial should have been discarded. Review of the manufactures recommendations for storage revealed a vial of Tubersol package which had been entered and in use for 30 days should be discarded. Review of the medication storage policy dated 3/1/14 revealed medications should be stored in accordance with the manufacturer's instructions. The operator failed to ensure designated staff stored Tubersol (PPD) according to manufactures recommendations.	S3215		