STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087162	A. BUILDING: _____ B. WING _____	R 03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJORIE'S HOME LLC	14601 TIMBER LAKE ROAD WICHITA, KS 67230

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{S 000}	INITIAL COMMENTS The following citations represent the findings of a revisit for correction order 18-25 and an abbreviated survey for investigation of complaint #126852 of the above home plus facility on 3/12/18, 3/13/18, 3/14/18, and 3/15/18.	{S 000}		
{S5155} SS=D	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus 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 agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 7 residents. The sample included 3 residents and 1 closed record reviewed. Based on record review and interview for 1 (#2030) of 1 closed record reviewed, operator/owner/licensed nurse B failed to provide or coordinate the provision of necessary health care services that met the needs of the resident in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #2030 revealed an admission date of 9/20/16 with diagnoses of chronic obstructive pulmonary disease and	{S5155}		

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

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{S5155}	Continued From page 1	{S5155}		

dementia.

Functional capacity screen dated 5/23/17 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility; was unable to perform management of medications and medical treatments; and experienced impaired decision making.

Negotiated service agreement/health care service plan dated 5/23/17 with amendments dated 10/20/17, 10/22/17, 11/21/17, and 12/5/17 documented certified staff to assist with activities of daily living and administer medications and listed the name of operator/owner/licensed nurse B responsible for the implementation and supervision of the health care service plan.

Nurse's notes contained the following entries:

2/5/18 at 5:30 p.m. operator/owner/licensed nurse B documented resident with non-productive cough. Breathing treatment done by nurse with good results. Cough sounding looser.

Note: the 2/5/18 entry lacked documentation of a licensed nurse assessment of the resident's cardiopulmonary status.

2/8/18 (time of entry not documented) operator/owner/licensed nurse B documented he/she reported to resident's medical care provider that resident had 1+ to 2+ edema (pitting edema with slight pitting to deeper pitting when fingertip pressure applied to the body part) of both ankles.

Note: the 2/8/18 entry lacked documentation of a licensed nurse assessment of the resident's

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{S5155}	Continued From page 2	{S5155}		

cardiopulmonary status.

2/15/18 (The next entry in nurse's notes after the 2/8/18 entry. The time of the entry not documented.) Licensed nurse C documented resident's cough reported to medical care provider. Resident coughs up yellow phlegm. Continue with breathing treatments as needed along with scheduled breathing treatments.

Note: the 2/15/18 entry lacked documentation of a licensed nurse assessment of the resident's cardiopulmonary status.

Resident's record contained a medical care provider's written order dated 2/15/18 to increase Mucinex (expectorant) to 1200 milligrams by mouth two times a day for one week and then return to routine dose of Mucinex 600 milligrams by mouth two times a day and start Prednisone (steroid) 40 milligrams daily for 3 days.

2/19/18 (The next entry in nurse's notes after the 2/15/18 entry. The time of the entry not documented.) Licensed nurse C documented that resident was sent to the hospital on 2/17/18 after staff called the nurse to report resident was not responding to questions, oxygen saturation "70's", heart rate 50, and unable to obtain blood pressure. Staff instructed to call 911.

Next entry in nurse's notes dated 2/27/18 by licensed nurse C documented resident remained in the hospital.

During an interview at 4:15 p.m. on 3/12/18, operator/owner/licensed nurse B stated resident was admitted to hospital with influenza B and pneumonia.

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{S5155}	Continued From page 3 During an interview at 2:19 p.m. on 3/13/18, operator/owner/licensed nurse B stated he/she thought she assessed resident's cardiopulmonary status on 2/8/18 and the days following "but if not documented (I) probably didn't." At 2:32 p.m. on 3/13/18, licensed nurse C stated he/she did not assess the resident's cardiopulmonary status on 2/15/18 or on 2/16/18. Operator/owner/licensed nurse B failed to provide or coordinate the provision of necessary health care services that met the needs of resident #2030 in accordance with the functional capacity screening and the negotiated service agreement.	{S5155}		
S5240 SS=E	26-42-105 (a) Resident Records (a) The administrator or operator of each home plus shall ensure the maintenance of a record for each resident in accordance with accepted professional standards and practices. (1) Designated staff shall maintain the record of each discharged resident who is 18 years of age or older for at least five years after the discharge of the resident. (2) Designated staff shall maintain the record of each discharged resident who is less than 18 years of age for at least five years after the resident reaches 18 years of age or at least five years after the date of discharge, whichever time period is longer. This REQUIREMENT is not met as evidenced by: KAR 26-42-105 (a) The facility reported a census of 7 residents. The	S5240		

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S5240	Continued From page 4	S5240		

sample included 3 residents and 1 closed record reviewed. Based on record review and interview for 3 (#2020, #2010, and #2000) of 3 residents sampled and 1 (#2030) closed record reviewed, licensed nurses failed to ensure the maintenance of a record for each resident with documentation in accordance with accepted professional standards of practice.

Findings included:

- Record review for resident #2020 revealed an admission date of 10/5/16 with diagnoses of Alzheimer's disease and anxiety.

Functional capacity screen dated 10/2/17 indicated resident was unable to perform management of medications; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and exhibited wandering behavior.

Negotiated service agreement/health care service plan dated 10/5/17 documented staff to administer medications to resident. The record contained an amended negotiated service agreement dated 11/29/17 that documented staff to notify nurse if resident not sleeping at night and to wake second staff person for assistance and to notify nurse if resident wandering unsafely during the day.

Review of the nurse's notes on 3/12/18 revealed a total of 6 entries by either operator/owner/licensed nurse B or licensed nurse C between 2/20/18 and 3/8/18. Five of the 6 entries lacked a time to indicate the time the licensed nurse documented the entry.

- Record review for resident #2010 revealed an

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S5240	Continued From page 5	S5240		

admission date of 10/4/17 with diagnoses of dementia and non-insulin dependent diabetes mellitus.

Functional capacity screen dated 10/3/17 indicated resident was unable to perform management of medications; required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility; experienced impaired short-term and long-term memory; and current/recent problems and risks for falls, socially inappropriate behaviors, and impaired decision making.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 10/3/17 with an amendment 11/29/17documented staff administered medications to the resident. The NSA/HCSP documented resident exhibited behaviors of yelling and hitting at staff and directed staff to offer to toilet resident, offer food, change position of resident, if hitting at staff to step back and leave resident ensuring resident was safe, and to notify nurse for direction if resident exhibited increased agitation. NSA/HCSP listed sit-to-stand lift and gait belt for transferring by 2 staff members. NSA/HCSP documented interventions to address resident's risk for falls as high/low bed, non-skid footwear, routine night checks, and use of a body alarm.

Review of the nurse's notes on 3/12/18 revealed a total of 9 entries by either operator/owner/licensed nurse B, licensed nurse C or licensed nurse D between 2/14/18 and 3/6/18. Each of the 9 entries lacked a time to indicate the time the licensed nurse documented the entry.

- Record review for resident #2000 revealed an

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S5240	Continued From page 6	S5240		

admission date of 6/7/16 with diagnoses of frontotemporal dementia and essential hypertension.

Functional capacity screen dated 5/18/17 indicated resident required physical assistance with bathing, dressing, and toileting; was independent with transferring and walking; was unable to perform medication management; and experienced impaired short-term memory, long-term memory; and decision making.

Negotiated service agreement dated 5/18/17 documented staff provided assistance with bathing, dressing, toileting, and administered medication to resident.

Review of the nurse's notes on 3/12/18 revealed a total of 5 entries by either operator/owner/licensed nurse B or licensed nurse C between 2/26/18 and 3/5/18. Each of the 5 entries lacked a time to indicate the time the licensed nurse documented the entry

- Record review for resident #2030 revealed an admission date of 9/20/16 with diagnoses of chronic obstructive pulmonary disease and dementia.

Functional capacity screen dated 5/23/17 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility; was unable to perform management of medications and medical treatments; and experienced impaired decision making.

Negotiated service agreement/health care service plan dated 5/23/17 with amendments dated 10/20/17, 10/22/17, 11/21/17, and 12/5/17

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S5240	Continued From page 7 documented certified staff to assist with activities of daily living and administer medications. Review of the nurse's notes on 3/12/18 revealed a total of 3 entries between 2/15/18 and 2/27/18 by either operator/owner/licensed nurse B or licensed nurse C. Each of the 3 entries lacked a time to indicate the time the licensed nurse documented the entry During an interview at 12:47 p.m. on 3/13/18, operator, owner/licensed nurse B stated facility did not have a policy for nursing documentation. For residents #2020, #2010, #2000, and #2030, licensed nurses failed to ensure the maintenance of a record for each resident with documentation in accordance with accepted professional standards of practice.	S5240		
S5251 SS=E	26-42-105 (f) (11) Resident Records 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 26-42-105(f)(11) The facility reported a census of 7 residents. The sample included 3 residents and 1 closed record reviewed. Based on record review and interview for 3 (#2020, #2010, and #2000) of 3 residents sampled and 1 (#2030) closed record reviewed,	S5251		

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S5251	Continued From page 8	S5251		

licensed nurses failed to ensure the resident's record contained documentation of the time of occurrence of all incidents, symptoms, and other indications of illness or injury including the results of the action taken.

Findings included:

- Record review for resident #2020 revealed an admission date of 10/5/16 with diagnoses of Alzheimer's disease and anxiety.

Functional capacity screen dated 10/2/17 indicated resident was unable to perform management of medications; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and exhibited wandering behavior.

Negotiated service agreement/health care service plan dated 10/5/17 documented staff to administer medications to resident. The record contained an amended negotiated service agreement dated 11/29/17 that documented staff to notify nurse if resident not sleeping at night and to wake second staff person for assistance and to notify nurse if resident wandering unsafely during the day.

The nurse's notes contained the following entries:

3/6/18 (time of entry not documented) operator/owner/licensed nurse B documented phone call from staff on 3/5/18 of (resident's) increased anxiety and leaning to side at lunch time, this nurse "ok'd" Ativan (to relieve anxiety) to help relax resident. Also documented in this entry that resident's spouse pointed out blisters on resident's hand and operator/owner/licensed nurse B notified resident's medical care provider

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of this.

Note: this entry did not include the time of phone call from staff, the time operator/owner/licensed nurse B instructed staff to administer medication, and the results of the action taken. Resident did not have an order for Ativan and record listed allergy to Ativan. During an interview at 2:39 p.m. on 3/12/18, operator/owner/licensed nurse B stated he/she meant to document Xanax instead of Ativan in his/her nurse's notes entry dated 3/6/18. The entry lacked documentation of the date and spouse reported blisters and date and time blisters were reported to medical care provider.

3/7/18 (time of entry not documented) operator/owner/licensed nurse B documented nurse here in A.M., blisters still intact to left hand.

Note: entry lacked time nurse assessed resident.

3/8/18 (time of entry not documented) operator/owner/licensed nurse B documented phone call from medical care provider's office for over-the-counter Eucerin or Cetaphil cream to upper back rash three times a day until healed. Nurse asked hospice nurse for an as needed order for medication to help with excessive secretions.

Note: entry lacked documentation of time of phone call from medical care provider, a nursing assessment of resident's rash, and time of request for order for medication for excessive secretions.

- Record review for resident #2010 revealed an admission date of 10/4/17 with diagnoses of dementia and non-insulin dependent diabetes

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S5251	Continued From page 10	S5251		

mellitus.

Functional capacity screen dated 10/3/17 indicated resident was unable to perform management of medications; required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility; experienced impaired short-term and long-term memory; and current/recent problems and risks for falls, socially inappropriate behaviors, and impaired decision making.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 10/3/17 with an amendment 11/29/17documented staff administered medications to the resident. The NSA/HCSP documented resident exhibited behaviors of yelling and hitting at staff and directed staff to offer to toilet resident, offer food, change position of resident, if hitting at staff to step back and leave resident ensuring resident was safe, and to notify nurse for direction if resident exhibited increased agitation. NSA/HCSP listed sit-to-stand lift and gait belt for transferring by 2 staff members. NSA/HCSP documented interventions to address resident's risk for falls as high/low bed, non-skid footwear, routine night checks, and use of a body alarm.

2/14/18 (time of entry not documented) operator/owner/licensed nurse B documented wound care to right lower leg.

Note: this entry lacked documentation of time wound care provided.

2/26/18 (time of entry not documented) licensed nurse C documented wound care and wound assessment.

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S5251	Continued From page 11 Note: entry lacked documentation of time wound care provided. 3/6/18 (time of entry not documented) operator/owner/licensed nurse B documented "Nurse here to reassess resident after rolling out of bed onto mat on floor. Hospice nurse here 3/5/18 late A.M. assessed (resident) also. Reported to me no injuries." Operator/owner/licensed nurse B documented he/she viewed video recording that staff found resident on floor beside bed at 5:30 a.m. and "(Resident) Denied pain and able to move ext. (extremities), went and got second staff because (resident) wanted to get up, and they assisted up in wheelchair." Note: the entry lacked the date staff found resident on floor and if a licensed nurse assessed the resident before staff moved the resident from the floor and into wheelchair. 3/6/18 the above entry continued by operator/owner/licensed nurse B with documentation of phone call from staff around lunch time that resident was yelling most of A.M. off and on and when taken to table for lunch resident hit table with arms and received a skin tear to top of left hand. Operator/owner/licensed nurse B documented resident received wound care to skin tear and staff instructed to administer topical Haldol (to treat mental/mood disorders). Operator/owner/licensed nurse B documented in this entry that at 8:00 p.m. phone call from staff reporting resident yelling out and refusing care and instructed staff to administer topical Haldol. Note: this part of entry did not specify if resident received the skin tear and required the 2 separate doses of Haldol on 3/5/18 or 3/6/18.	S5251		

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- Record review for resident #2000 revealed an admission date of 6/7/16 with diagnosis of frontotemporal dementia and essential hypertension.

Functional capacity screen dated 5/18/17 indicated resident required physical assistance with bathing, dressing, and toileting; was independent with transferring and walking; was unable to perform medication management; and experienced impaired short-term memory, long-term memory; and decision making.

Negotiated service agreement dated 5/18/17 documented staff provided assistance with bathing, dressing, toileting, and administered medication to resident.

Nurses notes contained the following entries:

2/26/18 (time of entry not documented) licensed nurse C documented resident's temperature at 99 degrees Fahrenheit and blood pressure 180/110. Licensed nurse C called medical care provider and received order for urinalysis and one-time order for anti-hypertensive medication. Staff obtained urine specimen and encouraged resident to drink fluids.

Note: entry lacked time of assessment, receipt of orders, when urine specimen obtained.

2/27/18 (time of entry not documented) licensed nurse C documented assessment of resident.

2/28/18 (time of entry not documented) licensed nurse C documented resident was seen by medical care provider with no new orders.

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S5251	Continued From page 13 2/28/18 (time of entry not documented) licensed nurse C documented third dose of antibiotic given intramuscularly. - Record review for resident #2030 revealed an admission date of 9/20/16 with diagnoses of chronic obstructive pulmonary disease and dementia. Functional capacity screen dated 5/23/17 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility; was unable to perform management of medications and medical treatments; and experienced impaired decision making. Negotiated service agreement/health care service plan dated 5/23/17 with amendments dated 10/20/17, 10/22/17, 11/21/17, and 12/5/17 documented certified staff to assist with activities of daily living and administer medications. Nurse's notes contained the following entries: 2/15/18 (The time of the entry not documented.) Licensed nurse C documented resident's cough reported to medical care provider. Resident coughs up yellow phlegm. Continue with breathing treatments as needed along with scheduled breathing treatments. Note: the 2/15/18 entry lacked documentation of a licensed nurse assessment of the resident's cardiopulmonary status and time resident's medical care provider notified. Resident's record contained a medical care provider's written order dated 2/15/18 to increase Mucinex (expectorant) to 1200 milligrams by	S5251		

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S5251	Continued From page 14 mouth two times a day for one week and then return to routine dose of Mucinex 600 milligrams by mouth two times a day and start Prednisone (steroid) 40 milligrams daily for 3 days. Resident's record lacked documentation of resident's response to these medications. 2/19/18 (The next entry in nurse's notes after the 2/15/18 entry. The time of the entry not documented.) Licensed nurse C documented that resident was sent to the hospital on 2/17/18 after staff called the nurse to report resident was not responding to questions, oxygen saturation "70's", heart rate 50, and unable to obtain blood pressure. Staff instructed to call 911. Note: this entry lacked documentation of the time staff found resident not responding, the time staff notified the nurse, and the time resident was transported out of facility. Next entry in nurse's notes dated 2/27/18 by licensed nurse C documented resident remained in the hospital. During an interview at 12:47 p.m. on 3/13/18, operator, owner/licensed nurse B stated facility did not have a policy for nursing documentation. For residents #2020, #2010, #2000, and #2030, licensed nurses failed to ensure each resident's record contained documentation of the time of occurrence of all incidents, symptoms, and other indications of illness or injury including the results of the action taken.	S5251		
{S5300} SS=E	26-42-205 (d) (1-2) Facility Administration of Medications	{S5300}		

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{S5300}	Continued From page 15 (d) Home administration of resident ' s medications. If a home 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 home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility reported a census of 7 residents. The sample included 3 residents and 1 closed record reviewed. Based on record review and interview for 3 (#2020, #2010, and #2000) of 3 residents sampled, operator/owner/licensed nurse B failed to ensure that all medications were administered to each resident in accordance with a medical care provider's order and professional standards of practice. Findings included: - Record review for resident #2020 revealed an admission date of 10/5/16 with diagnoses of Alzheimer's disease and anxiety. Functional capacity screen dated 10/2/17	{S5300}		

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{S5300}	Continued From page 16 indicated resident was unable to perform management of medications; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and exhibited wandering behavior. Negotiated service agreement/health care service plan dated 10/5/17 documented staff to administer medications to resident. The record contained an amended negotiated service agreement dated 11/29/17 that documented staff to notify nurse if resident not sleeping at night and to wake second staff person for assistance and to notify nurse if resident wandering unsafely during the day. Resident's record contained a written medical care provider's order dated 2/5/18 to discontinue the 2:00 a.m. dose of hydrocodone/acetaminophen (for pain relief) 7.5/325 milligrams because resident sleeping better. A licensed nurse discontinued the every 6 hour dosing of the medication on the medication administration record (MAR) and wrote a new entry on the MAR for the medication to be given three times a day. (Note: previous order had been written for hydrocodone/acetaminophen 7.5/325 milligrams per 15 milliliters, give 2.5 milliliters every 6 hours for pain.) The record contained a written medical care provider's order dated 2/10/18 for hydrocodone/acetaminophen 7.5/325 milligrams per 15 milliliters give 5 milliliters to equal 2.5 milligrams every 6 hours. The licensed nurse did not change the frequency of administration of the medication to every 6 hours on the MAR following receipt of the 2/10/18 order. Record lacked evidence a licensed nurse contacted medical care provider to clarify the frequency of administration. Certified medication aides continued to administer the medication 3	{S5300}		

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{S5300}	Continued From page 17	{S5300}		

times a day instead of every 6 hours as ordered.

During an interview at 1:51 p.m. on 3/13/18, licensed nurse C confirmed the current order frequency was for administration of the medication every 6 hours and he/she would contact medical care provider for clarification.

The February 1 through February 28, 2018 MAR contained initials on 2/18/18 to indicate a certified medication aide administered a bisacodyl suppository to resident. The entry on the MAR documented bisacodyl 10 milligrams suppository, insert 1 rectally daily as needed for constipation. The resident's record lacked documentation of an assessment by a licensed nurse to determine resident required administration of the suppository.

Review of the facility's policy for certified medication aide to administer PRN (as needed) medications documented the certified medication aide would notify the nurse on-call to report resident's symptoms to the nurse and the nurse would decide which PRN medication would be given.

During an interview at 1:54 p.m. on 3/13/18, operator/owner/licensed nurse B and licensed nurse C each stated they did not remember the certified medication aide calling prior to administration of the suppository.

Review of the March 2018 MAR revealed an entry for resident to receive alprazolam (for anxiety and trade name of Xanax) 1 milligram by mouth every 4 hours as needed for anxiety, restlessness, agitation. A certified medication aide documented on the back of the MAR that on 3/10/18 at 2:20 p.m. he/she administered Ativan (for anxiety

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{S5300}	Continued From page 18	{S5300}		

generic name lorazepam) 0.5 milligram one tablet per family/nurse request. Resident did not have a written medical care provider's order for Ativan and record documented resident had an allergy to Ativan. Resident's record lacked documentation of a licensed nurse assessment to determine if an anti-anxiety medication was indicated for the resident.

During an interview at 2:39 p.m. on 3/12/18, licensed nurse C stated the certified medication aide did not administer Ativan but did administer alprazolam but gave the wrong dose.

Operator/owner/licensed nurse B failed to ensure that all medications were administered to resident #2020 in accordance with a medical care provider's order and professional standards of practice.

- Record review for resident #2010 revealed an admission date of 10/4/17 with diagnoses of dementia and non-insulin dependent diabetes mellitus.

Functional capacity screen dated 10/3/17 indicated resident was unable to perform management of medications.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 10/3/17 with an amendment 11/29/17documented staff administered medications to the resident. The NSA/HCSP documented resident exhibited behaviors of yelling and hitting at staff and directed staff to offer to toilet resident, offer food, change position of resident, if hitting at staff to step back and leave resident ensuring resident was safe, and to notify nurse for direction if resident exhibited increased agitation.

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{S5300}	Continued From page 19 The February 2018 and March 2018 medication administration records (MAR) each contained an entry for resident to receive haloperidol (used to treat mental/mood disorders) 2.5 milligrams/milliliter topically apply 0.5 milligram (0.25 milliliter) every 4 hours as needed for increased agitation. The MARs indicated resident received this medication February 15, 18 (2 separate doses), 19, 21 and March 5, and 9, 2018. Resident's record lacked a written medical care provider's order for this medication. During an interview at 1:09 p.m. on 3/13/18, operator/owner/licensed nurse B and licensed nurse C each stated they could not locate a written medical care provider's order for topical haloperidol. Operator/owner/licensed nurse B failed to ensure that all medications were administered to resident #2010 in accordance with a medical care provider's order and professional standards of practice. - Record review for resident #2000 revealed an admission date of 6/7/16 with diagnoses of frontotemporal dementia and essential hypertension. Functional capacity screen dated 5/18/17 indicated resident was unable to perform medication management. Negotiated service agreement dated 5/18/17 documented staff administered medication to resident. Comparison of the written medical care provider's orders and medications entered on the February	{S5300}		

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{S5300}	Continued From page 20 2018 and March 2018 medication administration records revealed the lack of an order for ibuprofen 400 milligrams 1 tablet by mouth every 6 hours as needed for fever/pain. During an interview at 12:33 p.m. on 3/13/18, operator/owner/licensed nurse B and licensed nurse C each reviewed resident's record and each stated they could not find an order for resident to receive ibuprofen. Operator/owner/licensed nurse B failed to ensure that all medications were administered to resident #2000 in accordance with a medical care provider's order and professional standards of practice.	{S5300}		
S5301 SS=E	26-42-205 (d) (3) Facility Administration of Medications (d) (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 medication is administered.	S5301		

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S5301	Continued From page 21	S5301		

This REQUIREMENT is not met as evidenced by:
KAR 26-42-205(d)(3)(D)

The facility reported a census of 7 residents. The sample included 3 residents and 1 closed record reviewed. Based on record review and interview for 2 (#2020 and #2010) of 3 residents sampled, licensed nurse and certified medication aides failed to document the administration of each resident's medication in the resident's medication administration record (MAR) immediately before or following completion of the task.

Findings included:

- Record review for resident #2020 revealed an admission date of 10/5/16 with diagnoses of Alzheimer's disease and anxiety.

Functional capacity screen dated 10/2/17 indicated resident was unable to perform management of medications; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and exhibited wandering behavior.

Negotiated service agreement/health care service plan dated 10/5/17 documented staff to administer medications to resident. The record contained an amended negotiated service agreement dated 11/29/17 that documented staff to notify nurse if resident not sleeping at night and to wake second staff person for assistance and to notify nurse if resident wandering unsafely during the day.

Nurses notes contained the following entries:

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S5301	Continued From page 22 3/6/18 (time of entry not documented) operator/owner/licensed nurse B documented phone call from staff on 3/5/18 of (resident's) increased anxiety and leaning to side at lunch time, this nurse "ok'd" Ativan (to relieve anxiety) to help relax resident. Note: resident did not have an order for Ativan and record listed allergy to Ativan. 3/8/18 at 11:30 a.m. licensed nurse C documented resident bending down, gait more unsteady. Asked resident if he/she was tired and resident stated 'yes.' Xanax (to relieve anxiety) 1 milligram given by mouth and effective 30 minutes later. Review of the resident's March 2018 MAR revealed the lack of documentation of administration of Xanax on 3/8/18. The MAR lacked documentation of administration of an anti-anxiety medication on 3/5/18. Review of the facility's Medication Administration Policy documented staff to record the administration of the resident's medication in the resident's MAR as they were preparing the medication. During an interview at 2:39 p.m. on 3/12/18, operator/owner/licensed nurse B stated he/she meant to document Xanax instead of Ativan in his/her nurse's notes entry dated 3/6/18 and confirmed the certified medication aide did not document medication administration on the MAR. Licensed nurse C stated he/she administered the dose of Xanax on 3/8/18 and did not document this on the MAR. Licensed nurse documented during the interview that he/she administered	S5301		

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S5301	Continued From page 23 Xanax at 11:30 a.m. on 3/8/18. The February 1 through February 28, 2018 MAR contained initials on 2/18/18 to indicate a certified medication aide administered a bisacodyl suppository to resident. The entry on the MAR documented bisacodyl 10 milligrams suppository, insert 1 rectally daily as needed for constipation. The MAR lacked documentation of the reason for administration of the medication and the results of administering the medication. The facility policy for Medication Administration and policy for Certified Medication Aide to Administer PRN (as needed) Medications each documented person administering medication to document on the back of the MAR the reason for and the results of the PRN medication. Licensed nurse C and certified medication aides failed to document the administration of medications to resident #2020 in the resident's MAR immediately before or following completion of the task. - Record review for resident #2010 revealed an admission date of 10/4/17 with diagnoses of dementia and non-insulin dependent diabetes mellitus. Functional capacity screen dated 10/3/17 indicated resident was unable to perform management of medications. Negotiated service agreement/health care service plan (NSA/HCSP) dated 10/3/17 with an amendment 11/29/17documented staff administered medications to the resident. The NSA/HCSP documented resident exhibited behaviors of yelling and hitting at staff and	S5301		

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S5301	Continued From page 24	S5301		

directed staff to offer to toilet resident, offer food, change position of resident, if hitting at staff to step back and leave resident ensuring resident was safe, and to notify nurse for direction if resident exhibited increased agitation.

Comparison of the nurse's notes and the resident's February 2018 and March 2018 revealed the following:

2/15/18 (no entry time documented) Licensed nurse C documented nurse here, 1:10 p.m. topical Haldol (used to treat mental/mood disorders) 0.5 milligram given behind right ear. Resident yelling, kicking, unable to calm. Monitored resident and continued to have restlessness, agitation, anxiety so staff medicated with Ativan (to treat anxiety) 0.5 milligram by mouth at 1:45 p.m. and was effective by 2:00 p.m. The resident's MAR lacked initials of certified medication aide to indicate resident received Ativan on 2/15/18.

2/22/18 (no entry time documented) licensed nurse D documented resident with agitation, yelling when medical care provider present. Haldol 0.5 milligrams topical applied. The MAR lacked the initials of a licensed nurse or certified medication aide to indicate resident received topical Haldol on 2/22/18.

Review of the back page of page 2 of the February 2018 MAR revealed documentation on 2/20/18 by a certified medication aide that he/she administered Ativan 0.5 milligram at 4:00 a.m. The certified medication aide did not initial on the front of the MAR on 2/20/18 to indicate resident received Ativan and record lacked an assessment by a licensed nurse to determine resident required the medication. On 2/26/18 at 3:30 a.m.

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S5301	Continued From page 25 a certified medication aide documented he/she was instructed by licensed nurse C to administer Haldol 0.5 milligram but did not initial the front of the MAR on 2/26/18 to indicate resident received medication. Certified medication aides failed to document the administration of medications to resident #2010 in the resident's MAR immediately before or following completion of the task.	S5301		