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MANOR OF THE PLAINS	200 CAMPUS DRIVE DODGE CITY, KS 67801

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S 000	INITIAL COMMENTS The following citations represent the findings of an resurvey at the above named assisted living facility conducted on 3/5/2018 and 3/6/2018.	S 000		
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 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 16 residents. The sample included 3 residents. Based on observation, interview and record review the facility failed to ensure designated staff developed a negotiated service agreement that included a description of the services the resident would receive; identification of the provider of each service; and identification of each party	S3085		

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

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responsible for payment if outside resources provided a service for 3 (#350, #351, #352) of 3 residents.

Findings included:

- Review of resident #350's medical record revealed the resident admitted to the facility on 7/12/17 with diagnoses of congestive heart failure, type 2 diabetes, edema and macular degeneration.

Review of the functional capacity screen dated 7/11/17 revealed the resident needed physical assistance with bathing, walking, and management of medications and treatments.

Review of the residents Negotiated Service agreement (NSA) dated 7/13/17 revealed the facility staff would provide services as indicated above. Staff check marked the box for ambulation/transfers, toileting assist, personal hygiene, and bathing. It identified the resident needed increased assistance with activities of daily living now due to left knee/ankle sprain. The NSA also revealed the resident received therapy services through an outside resource but did not indicate who was responsible for payment of service.

During an interview on 3/6/18 at 9:45 AM administrative nursing staff B reported he/she did not realize the payment source was not on the NSA.

Review of the negotiated service agreement (NSA) policy dated 8/2015 revealed the NSA would include the service to be provided, how the services will be provided and include identification of the party responsible for payment of such

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services.

The administrator failed to ensure designated staff included the payment source for services provided by outside resources on the NSA.

- Review of resident #351's medical record revealed he/she admitted to the facility on 8/16/17 with diagnoses of heart disease, atrial fibrillation, hypertension, edema, history of falls and pain.

Review of the functional capacity screen dated 11/15/17 revealed the resident required physical assistance with bathing, bladder incontinence, and management of medications and treatments.

Review of the residents negotiated service agreement (NSA) dated 8/17/17 identified facility staff would manage medications and treatments, and assist with bathing. The NSA revealed the use of oxygen services was "N/A" not applicable.

Review of the residents MAR revealed a physician's order dated 2/14/18 revealed an order for PRN oxygen at 2L/nasal cannula as needed for respiratory distress.

Review of the resident's medical record revealed 2 additional NSA addendums but neither contained information regarding the provision of oxygen services, who provided the service and who was responsible for the payment of the service.

Review of the nursing notes dated 2/15/18 revealed the nurse spoke with the oxygen provider and Medicare would not cover the oxygen use so it would have to be billed "private pay". The nurse notified family and received permission to go ahead with getting the oxygen.

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S3085	Continued From page 3 During an interview on 3/6/18 at 9:47 AM administrative nursing staff B reported he/she added the oxygen use to the health service plan but just didn't get it on the NSA. Review of the negotiated service agreement (NSA) policy dated 8/2015 revealed the NSA would include the service to be provided, how the services will be provided and include identification of the party responsible for payment of such services. The administrator failed to ensure designated staff included on the NSA what service the resident received, who provided it and the payment source for services provided by outside resources - Review of resident #352's medical record revealed the resident admitted to the facility on 3/6/17 with diagnoses of chronic atrial fibrillation, anemia, chronic obstructive pulmonary disease, major depressive disorder and major depressive disorder. Review of the resident's functional capacity screen dated 3/16/17 revealed the resident needed physical assistance with showers, dressing, and management of medications and treatments. The resident also needed assistance related to cognitive loss and hearing loss. Review of the residents negotiated service agreement dated 4/3/17 the facility staff managed and administered the resident's medications and treatments. Under services provided by outside resources: Oxygen "N/A" (not applicable).	S3085		

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S3085	Continued From page 4 The record included an order dated 11/7/17 for oxygen and a self-administration assessment dated 1/25/18 for the resident to self-administer eye drops. The NSA lacked a description of these services including the provider and payment source for the outside provider. Observation on 3/6/18 at 7:35 the resident sat on the side of his/her bed and had oxygen on via nasal cannula. There also sat a bottle of refresh lubricating eye drops on the bedside table. The resident stated he/she put those in himself for his dry eyes. During an interview on 3/6/18 at 9:47 AM administrative nursing staff B reported he/she would normally revise the health service plan to include oxygen and self-administration of medications. Review of the negotiated service agreement (NSA) policy dated 8/2015 revealed the NSA would include the service to be provided, how the services will be provided and include identification of the party responsible for payment of such services. The administrator failed to ensure designated staff developed a NSA for each resident that included a description of services the resident would receive, identification of the provider of each service and identification of the party responsible for payment if outside resources provided the service for 3 (#350, #351, #352) of 3 residents.	S3085		
S3090 SS=E	26-41-202 (c) Admission Negotiated Service Agreement	S3090		

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S3090	Continued From page 5 (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(c) The facility reported a census of 16 residents. The sample included 3 residents. Based on interview and record review the facility failed to ensure designated staff developed an initial negotiated service agreement at admission for 3 (#350, #351, #352) of 3 residents. Findings included: - Review of resident #350's medical record revealed the resident admitted to the facility on 7/12/17 with diagnoses of congestive heart failure, type 2 diabetes, edema and macular degeneration. Review of the residents Negotiated Service agreement (NSA) dated 7/13/17 identified an admission date of 7/12/17 but was not completed until 7/13/17, 1 day after admission to the facility. During an interview on 3/6/18 at 9:40 AM administrative nursing staff B reported he/she typically completed the NSA on the first day the resident was in the facility and typically had the resident and family sign it on the day they reviewed it. Staff B was not sure why it was signed the day after admission. - Review of resident #351's medical record	S3090		

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revealed he/she admitted to the facility on 8/16/17 with diagnoses of heart disease, atrial fibrillation, hypertension, edema, history of falls and pain.

Review of the residents negotiated service agreement (NSA) dated 8/17/17 identified an admission date of 8/16/17 but was not completed until 8/17/17, 1 day after admission to the facility.

During an interview on 3/6/18 at 9:40 AM administrative nursing staff B reported he/she typically completed the NSA on the first day the resident was in the facility and typically had the resident and staff sign it on the day they reviewed it. Staff B was not sure why it was signed the day after admission.

- Review of resident #352's medical record revealed the resident admitted to the facility on 3/6/17 with diagnoses of chronic atrial fibrillation, anemia, chronic obstructive pulmonary disease, major depressive disorder and major depressive disorder.

Review of the residents negotiated service agreement dated 4/3/17 identified the resident admitted to the facility on 3/16/17. Staff completed the negotiated service agreement 18 days after the resident admitted into the facility.

During an interview on 3/6/18 at 9:40 AM administrative nursing staff B reported he/she did not know why staff completed the NSA so late because he/she was not at the facility at that time.

Review of the negotiated service agreement dated 8/15/17 revealed a negotiated service agreement will be completed according to state regulations: before or on admission, including

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S3090	Continued From page 7 return from a hospital stay of 72 hours or more. The administrator failed to ensure designated staff completed an initial negotiated service agreement at time of admission for 3 (#350, #351, #352) of 3 residents.	S3090		
S3166 SS=E	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 (e) The facility reported a census of 16 residents. Based on record review and interview the administrator failed to delegate the nursing procedure of blood sugar monitoring to each certified medication aide 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 which is not part of the certified medication aide curriculum. Certified staff C had a hire date of 10/6/16 and completion of delegation done on 6/13/17, 6 months after being	S3166		

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S3166	Continued From page 8 hired. Certified staff E was hired on 5/31/16 and staff F hired on 1/9/17 and neither one had evidence of delegation of duties in their record. During an interview on 3/5/18 at approximately 10:30 AM administrative nursing staff B reported the certified medication aide or the nurse checked the blood sugars. During an interview on 3/6/18 at 11:45 AM administrative nursing staff B reported he/she did not have delegation checks for certified staff E or F. Review of the Medication Aide - expanded role in assisted living policy dated 6/2009 revealed delegation of nursing tasks (beyond tasks identified in state approved curriculum) to designated medication aids. The registered nurse will instruct the medication aide in the performance of the task - document in writing the medication aide's demonstration of competency and will have medication aide sign documentation that they concur with competency. The administrator failed to ensure certified medication aides were properly trained and signed off on completion of blood glucose testing which is a nursing procedure.	S3166		
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	S3200		

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S3200	Continued From page 9 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 16 residents. The sample included 3 residents. Based on interview and record review the administrator failed to ensure designated staff administered medications in accordance with professional standards of practice for 2 (#351 and #352) of 3 residents. Findings included: - Review of resident #351's medical record revealed he/she admitted to the facility on 8/16/17 with diagnoses of heart disease, atrial fibrillation, hypertension, edema, history of falls and pain. Review of the Functional Capacity Screen dated 11/15/17 revealed the resident required physical assistance with management of medications and treatments. Review of the Negotiated Service Agreement dated 8/17/17 revealed facility staff would	S3200		

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manage and administer medications and treatments.

Review of the December 2017 signed physicians recap order sheet included the following orders:
Norco 5mg (milligrams) / 325mg tablet every 6 hours as needed (PRN) for pain.
Mylanta Maximum strength liquid 30 ml (milliliters) once daily PRN for heartburn.

On 3/1/18 the physician wrote orders for Oxycodone HCL (narcotic pain medication) 5mg tablet 1 PRN every 6 hours for pain and an order for Lorazepam 0.5mg tablet 1 PRN every 6 hours as needed for anxiety.

Review of the medication administration record (MAR) for 2/15/18 - 3/14/18 revealed the following:
The resident received Norco 5/325mg 10 times for "discomfort" or "back pain" with evidence staff only followed up 1 time for effectiveness of the pain medication.
The resident received Oxycodone 5mg 7 times for "back pain" or "back and foot pain" with evidence staff only followed up 3 times for effectiveness of the pain medication. One of those times a licensed nurse administered the medication.
The resident received Lorazepam 0.5mg 1 time for "very shaky and calling often" with no follow up for effectiveness.
The above medications were administered by a certified medication aide (except for 1) and the record lacked evidence the nurse was consulted prior to the administration of PRN medications that lacked a specific reason for giving.

During an interview on 3/6/18 at 7:06 AM certified staff A reported the certified medication aide

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(CMA) gives the PRN medications. The nurse was supposed to direct the CMA on what to do and then the nurse needed to go back and assess the effectiveness of the medication.

During an interview on 3/6/18 at 9:53 AM administrative staff B reported if a resident had an order for a PRN pain medication the CMA could go ahead and administer the medication according to the order without contacting the nurse. If the CMA had any questions about time frames or anything else they could call staff B. Typically staff B would expect the certified staff to go back and ask the resident how he/she felt and if the resident had no relief staff B would expect certified staff to call him/her back with a report.

The administrator failed to ensure designated staff administered medications according to professional standards of practice.

- Review of resident #352's medical record revealed the resident admitted to the facility on 3/6/17 with diagnoses of chronic atrial fibrillation, anemia, chronic obstructive pulmonary disease, major depressive disorder and major depressive disorder.

Review of the functional capacity screen dated 3/16/17 revealed the resident required physical assistance of staff to manage medications and treatments.

Review of the negotiated service agreement dated 4/3/17 revealed facility staff would manage and administer medications.

Review of the physician's order dated 2/6/18 revealed staff initiated acetaminophen 650 mg tablet every 4 hours as needed for mild to

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moderate discomfort per physician's standing orders.

Review of the medication administration record (MAR) dated 2/15/18 to 3/14/18 revealed certified medication staff administered Tylenol 325mg 2 tablets 3 times for shoulder pain and 7 times for general discomfort with staff follow up for effectiveness 1 time.

The above medications were administered by a certified medication aide and the record lacked evidence the nurse was consulted prior to the administration of PRN medications that lacked a specific reason for giving.

During an interview on 3/6/18 at 7:06 AM certified staff A reported the certified medication aide (CMA) gives the PRN medications. The nurse was supposed to direct the CMA on what to do and then the nurse needed to go back and assess the effectiveness of the medication.

During an interview on 3/6/18 at 9:53 AM administrative staff B reported if a resident had an order for a PRN pain medication the CMA could go ahead and administer the medication according to the order without contacting the nurse. If the CMA had any questions about time frames or anything else they could call staff B. Typically staff B would expect the certified staff to go back and ask the resident how he/she felt and if the resident had no relief staff B would expect certified staff to call him/her back with a report.

Review of the medication policy dated 10/2017 revealed "If a PRN medication is administered by a CMA/CMT, exact instructions regarding dosage, time intervals and the specific reason for giving (i.e. right hip pain, headache, temp > 100,

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S3200	Continued From page 13 etc.) must be followed. Administration of the PRN medication will also be documented on the back side of the MAR ... Follow-up of the results will be documented and discussed with the licensed nurse." The administrator failed to ensure designated staff administered medications according to professional standards of practice for resident #351 and #352.	S3200		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 16 residents.	S3280		

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MANOR OF THE PLAINS	200 CAMPUS DRIVE DODGE CITY, KS 67801

(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
S3280	Continued From page 14 Based on interview and record review the administrator failed to ensure disaster and emergency preparedness by failing to ensure the performance of quarterly reviews of the facility's emergency management plan with all employees and all residents. Findings included: - Review of the fire drill records revealed the facility had fire drills for assisted living on 6/23/17, 10/23/17, 11/14/17, 12/26/17, and 1/2/18. The records identified different staff that were involved in the drill which also included staff from health care. The records lacked evidence of reviewing the plan with all residents and all assisted living staff. Review of the resident council minutes dated 3/27/18 revealed discussion of the fire drill process which staff planned to conduct the following month. During an interview on 3/5/18 at 11:30 AM administrative staff C reported there were no other resident council minutes where the emergency disaster plan was discussed with residents. Staff C also reported he/she did not have anything that showed specifically reviewing of the emergency management plan quarterly with all residents and all staff. The administrator failed to ensure he/she reviewed the emergency management plan with all residents and assisted living staff quarterly.	S3280		