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	B088002	A. BUILDING: _____ B. WING _____	12/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey of the above home plus facility on 12/18/17, 12/19/17, 12/20/17, 12/21/17, 12/26/17, and 12/27/17.	S 000		
S5026 SS=D	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(1)(C) The facility reported a census of 5 residents. The sample included 3 residents and 2 residents focus reviewed. Based on record review and interview for 1 (#116) of 3 residents sampled, the operator failed to ensure the resident was not subjected to exploitation. Findings included: - Record review for resident #116 revealed an admission date of 7/24/17 and diagnoses of type 2 diabetes mellitus, atrial fibrillation, and hypertension. Functional capacity screen dated 7/21/17	S5026		

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

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S5026	Continued From page 1	S5026		

indicated resident did not experience impaired cognition, required physical assistance with money management, able to communicate, and resident usually understood verbal communication by others.

Negotiated service agreement dated 7/24/17 documented resident's family and/or friends took resident shopping and resident's durable power of attorney assisted resident with personal matters that included bill paying. The negotiated service agreement did not specify the person responsible to assist resident with financial decisions.

By confidential interview it was reported that sometime around the first of December 2017, an employee talked resident #116 into giving him/her $5,000. The employee drove resident to the bank and resident gave the employee $5,000. Employee told resident #116 that he/she would pay the $5000 back the following Wednesday but did not do this. Person being interviewed stated the facility operator was aware this employee took money from the resident. During this same interview it was reported resident gave another employee $140.

During an interview at 2:33 p.m. on 12/19/17, operator B stated he/she was aware that resident offered to give money to two employees but was unaware that employees took money from the resident. Operator B stated he/she discouraged employees from taking money from the resident.

Operator B provided a written statement on 12/19/17 that on 12/2/17 an employee told him/her that the employee needed money for personal reasons and later that day resident #116 asked operator B if the employee "was good for the money." Operator B wrote that he/she told

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S5026	Continued From page 2	S5026		

resident #116 that employees cannot accept money (from residents). Operator B stated he/she told the employee not to accept "gift" from residents. Operator B wrote that he/she was aware resident had offered to give another employee money to take resident on errands to help that employee with finances. Operator B wrote this employee told him/her that the employee "did not need" the resident's money.

Review of the facility's "Prevention of Resident Abuse, Neglect, and Exploitation of Resident Property Policy" revealed the statement of "This facility will enforce policies and procedures that protect each resident from abuse, neglect, and exploitation of property by employees of the facility, other residents, consultants, volunteers, employee of other agencies serving the resident, family members and legal guardians, friends, or other individuals." The policy defined exploitation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent."

At 3:15 p.m. on 12/19/17 the employee alleged to have taken $140 from resident #116 provided a written statement that resident #116 offered to give him/her money but that he/she refused to take money from the resident. The employee documented that he/she informed the operator of this.

At 3:35 p.m. on 12/19/17, the employee alleged to have taken $5,000 from resident #116 provided a written statement that he/she came to work on 12/2/17 crying about a personal matter and (resident #116) offered to give him/her $5,000. The employee drove resident #116 to the bank.

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S5026	Continued From page 3 Resident gave a check for $5,000 to the employee. Employee documented he/she did not pay the resident back because he/she needed someone to co-sign a loan. The operator failed to ensure resident #116 was not subjected to exploitation.	S5026		
S5028 SS=E	26-42-101 (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 home 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.	S5028		

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S5028	Continued From page 4 This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(3)(A)(B)(C)(D) The facility reported a census of 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on record review and interview for 2 (#116 and #117) of 3 residents sampled, the operator failed to report allegations of potential exploitation and neglect to the department within 24 hours, failed to conduct a thorough investigation within 5 working days of the incidents, and failed to take appropriate corrective actions when an alleged violation was verified. Findings included: - Record review for resident #116 revealed an admission date of 7/24/17 and diagnoses of type 2 diabetes mellitus, atrial fibrillation, and hypertension. Functional capacity screen dated 7/21/17 indicated resident did not experience impaired cognition, required physical assistance with money management, able to communicate, and resident usually understood verbal communication by others. Negotiated service agreement dated 7/24/17 documented resident's family and/or friends took resident shopping and resident's durable power of attorney assisted resident with personal matters that included bill paying. The negotiated service agreement did not specify the person responsible to assist resident with financial decisions. By confidential interview it was reported that	S5028		

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S5028	Continued From page 5	S5028		

sometime around the first of December 2017, an employee talked resident #116 into giving him/her $5,000. The employee drove resident to the bank and resident gave the employee $5,000. Employee told resident #116 that he/she would pay the $5000 back the following Wednesday but did not do this. Person being interviewed stated the facility operator was aware this employee took money from the resident.

During an interview at 2:33 p.m. on 12/19/17, operator B stated he/she was aware that resident offered to give money to two employees but was unaware that employees took money from the resident. Operator B stated he/she discouraged employees from taking money from the resident. Operator B stated he/she did not report the allegation to the department, did not conduct a written investigation, and did not take corrective action.

Operator B provided a written statement on 12/19/17 that on 12/2/17 an employee told him/her that the employee needed money for personal reasons and later that day resident #116 asked operator B if the employee "was good for the money." Operator B wrote that he/she told resident #116 that employees cannot accept money (from residents). Operator B stated he/she told the employee not to accept "gift" from residents.

Review of the facility's "Prevention of Resident Abuse, Neglect, and Exploitation of Resident Property Policy" revealed the statement of "This facility will enforce policies and procedures that protect each resident from abuse, neglect, and exploitation of property by employees of the facility, other residents, consultants, volunteers, employee of other agencies serving the resident,

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S5028	Continued From page 6	S5028		

family members and legal guardians, friends, or other individuals." The policy defined exploitation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent."

At 3:35 p.m. on 12/19/17, the employee alleged to have taken $5,000 from resident #116 provided a written statement that he/she came to work on 12/2/17 crying about a personal matter and (resident #116) offered to give him/her $5,000. The employee drove resident #116 to the bank. Resident gave a check for $5,000 to the employee. Employee documented he/she did not pay the resident back because he/she needed someone to co-sign a loan.

Operator B failed to report an allegation of exploitation of resident #116 to the department within 24 hours, failed to conduct a thorough investigation within 5 working days of the incident, and failed to take appropriate corrective actions when the alleged violation was verified.

- Record review for resident #117 revealed an admission date of 5/1/17 with diagnoses of history of stroke and dementia.

Functional capacity screen dated 4/19/17 indicated resident required supervision with transferring; physical assistance with walking; was at risk for falls; blindness caused by stroke; and experienced impaired short term memory, long term memory, memory recall, and decision making.

Negotiated service agreement/health care service plan dated 5/1/17 documented resident would

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S5028	Continued From page 7	S5028		

receive staff assistance with transferring and mobility.

At 5:19 p.m. on 12/18/17, surveyor observed a staff member assist resident to stand from sofa in living room and hold resident's hands to guide resident while walking.

During an interview at 10:27 a.m. on 12/19/17, certified staff D stated resident experienced a fall last Thursday (12/14/17). Certified staff D explained that resident had been restless and was sitting on sofa in living room while certified staff D was in another resident's room administering medications. Certified staff D stated that a visitor heard a book shelf fall and found resident (#117) on floor in living room with bookshelf on resident. Certified staff D stated resident received an abrasion to forehead and back of head and a bruise on left lower leg. Certified staff D stated he/she called licensed nurse C who came to the facility to assess the resident and instructed certified staff D not to leave resident unattended when providing care to other residents. Certified staff D stated he/she was the only employee in the facility at the time of the incident.

At 12:40 p.m. on 12/19/17, operator B stated he/she did not report the incident to the department and did not investigate the incident. Operator B stated after the resident's fall staff members were instructed to take the resident with them when going to another resident's room when only one certified staff member on duty.

Operator B failed to report an allegation of potential resident neglect of resident #117 to the department within 24 hours and failed to conduct a thorough investigation within 5 working days of

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S5028	Continued From page 8 the incident.	S5028		
S5080 SS=D	26-42-201 (a) (b) Functional Capacity Screen on Admission (a) On or before each individual ' s admission to a home plus, 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. The administrator or operator may integrate the department ' s screening form into a form developed by the home, 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: KAR 26-42-201(a)(b) The facility reported a census of 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on record review and interview for 1 (#118) of 2 residents focus reviewed, the operator failed to complete a functional capacity screen according to each element and definition specified by the department and failed to ensure a licensed nurse assessed the resident whose functional capacity screening indicated the need	S5080		

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S5080	Continued From page 9 for health care services. Findings included: - Record review for resident #118 indicated an admission date of 5/29/17 for adult day care services. Record documented resident with a diagnosis of dementia. Functional capacity screen completed and signed by operator B dated 5/19/17 indicated resident was independent with activities of daily living; unable to perform management of medications and medical treatments; was frequently incontinent of urine; and experienced impaired vision and impaired decision making. Operator B did not score the cognition section of the functional capacity screen. Negotiated service agreement/health care service plan dated 5/19/17 documented health care service provided by facility staff members of incontinence management. During an interview at 12:19 p.m. on 12/19/17, licensed nurse C stated he/she did not assess resident #118. Interview at 12:25 p.m. on 12/19/17, operator B stated he/she did not score the resident's cognition on the functional capacity screen because he/she did not understand how to score (short term memory, long term memory, memory/recall, and decision making). Operator failed to complete a functional capacity screen for resident #118 according to each element and definition specified by the department and failed to ensure a licensed nurse assessed the resident whose functional capacity	S5080		

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S5080	Continued From page 10 screening indicated the need for health care services.	S5080		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c)(1) The facility reported a census of 5 residents and 2 adult day care residents. The sample included 3 residents and 2 resident focus reviewed. Based on record review and interview for 1 (#115) of 3 residents sampled, designated staff failed to conduct a screening to determine the resident's functional capacity at least once every 365 days. Findings included: - Record review on 12/19/17 for resident #115 revealed an admission date of 12/16/16 and diagnosis of end-stage renal disease. Record contained an admission functional capacity screen dated 12/16/16 completed by operator B and licensed nurse C that indicated resident was unable to perform management of	S5085		

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S5085	Continued From page 11 medications and medical treatments; required supervision with bathing, transferring, and walking; and was independent with dressing, toileting, and eating. The record lacked a subsequent functional capacity screen. During an interview at 9:54 a.m. on 12/19/17, operator B stated that yesterday he/she discovered resident's functional capacity screen was due on 12/16/17. Designated staff failed to conduct a screening to determine resident #115's functional capacity at least once every 365 days.	S5085		
S5105 SS=D	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus 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 26-42-202(a)(1)(2)(3)	S5105		

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S5105	Continued From page 12 The facility reported a census of 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on record review, interview, and observation for 1 (#115) of 3 residents sampled, the operator failed to ensure the resident's negotiated service agreement (NSA) included the identity of an outside resource, the service provided, and the party responsible for payment to the outside resource. Findings included: - Record review for resident #115 revealed an admission date of 12/16/16 with diagnoses of end stage renal disease, congestive heart failure, and atrial fibrillation. Licensed nurse C documented in the ordered therapies and treatments section of the functional capacity screen dated 12/16/16 that resident required oxygen therapy at 3 liters per minute per nasal cannula. NSA dated 12/16/16 documented facility management of oxygen. The NSA lacked the identity of the provider of the oxygen and supplies and the party responsible for payment to the outside provider. During an interview at 12:50 p.m. on 12/19/17, operator B confirmed the resident's NSA lacked the identity of the outside provider and party responsible for payment. At 1:40 p.m. on 12/19/17, observed resident in room with nasal cannula in place and tubing connected to an oxygen concentrator.	S5105		

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S5105	Continued From page 13 The operator failed to ensure resident #115's NSA included the identity of an outside resource, the service provided, and the party responsible for payment to the outside resource.	S5105		
S5116 SS=E	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(1)(2) The facility reported a census of 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on record review and interview for 3 (#115, #117, and #116) of 3 residents sampled, the operator failed to ensure the review and revision of each negotiated service agreement (NSA) at least once every 365 days and following any significant change in condition, as defined in K.A.R. 26-39-100.	S5116		

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S5116	Continued From page 14 Findings included: - Record review on 12/19/17 for resident #115 revealed an admission date of 12/16/16 and diagnosis of end-stage renal disease. Record contained an admission NSA dated 12/16/16 that documented facility staff to provide meal service; housekeeping; laundry; assistance with bathing, toileting, transferring, and medications; monitor vital signs; and wound care. The NSA lacked evidence of review or revision since 12/16/16. During an interview at 9:54 a.m. on 12/19/17, operator B stated that yesterday he/she discovered resident's NSA was due for review and revision. The operator failed to ensure the review and revision of the NSA for resident #115 at least once every 365 days. - Record review for resident #116 revealed an admission date of 7/24/17 and diagnoses of type 2 diabetes mellitus, atrial fibrillation, and hypertension. Record contained an order 7/24/17 for home health physical therapy for right hip pain post fall. NSA dated 7/24/17 documented an outside service by a home health provider for physical therapy. The record did not contain evidence that resident was still receiving physical therapy. During an interview at 12:11 p.m. on 12/19/17, operator B stated physical therapy was	S5116		

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S5116	Continued From page 15 discontinued and NSA was not revised to reflect this. Operator failed to ensure the revision of the NSA for resident #116 following any significant change in condition, as defined in K.A.R. 26-39-100. - Record review for resident #117 revealed an admission date of 5/1/17 with diagnoses of history of stroke and dementia. NSA dated 5/1/17 included hospice services. During an interview at 12:27 p.m. on 12/19/17, licensed nurse C stated resident improved after admission to the facility and hospice nurse discontinued hospice services. Licensed nurse C stated he/she did not revise the NSA to discontinue hospice services. Operator failed to ensure the revision of the NSA for resident #117 following any significant change in condition, as defined in K.A.R. 26-39-100.	S5116		
S5117 SS=D	26-42-202 (e) NSA Nurse Participation (e) A licensed nurse shall participate in the development, review, and revision of the negotiated service agreement if the resident's functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(e)	S5117		

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S5117	Continued From page 16 The facility reported a census of 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on record review and interview for 1 (#119) of 2 residents focus reviewed, the operator failed to ensure a licensed nurse participated in the revision of the negotiated service agreement (NSA) when the resident's functional capacity screen indicated the need for health care services. Findings included: - Record review for resident #119 revealed an admission date of 11/30/15 with diagnosis of chronic renal failure. Significant change functional capacity screen dated 5/12/17 indicated resident required physical assistance with eating; was unable to perform bathing, dressing, toileting, transferring, walking, and management of medications and treatments; was occasionally incontinent of urine; experienced impaired short term memory, long term memory, memory recall, and decision making; at risk for falls; exhibited socially inappropriate disruptive behavior; and required a wheelchair for mobility. The record contained an NSA dated 12/1/15 that had not been reviewed or revised to reflect the resident's change in condition. At 11:12 a.m. on 12/19/17, operator provided an addendum to the NSA dated 5/30/17 that documented an increase in assistance with bathing, dressing, toileting, transferring, mobility, and incontinence care based on functional capacity screen dated 5/12/17. The addendum contained the signature of the resident's legal	S5117		

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S5117	Continued From page 17 representative and the operator. The addendum did not contain the name of the licensed nurse. Operator stated the nurse was not involved in the revision to the NSA. The operator failed to ensure a licensed nurse participated in the revision of the NSA for resident #119 when the resident's functional capacity screen indicated the need for health care services.	S5117		
S5155 SS=E	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 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on record review, observation, and interview for 3 (#116, #115, and #117) of 3 residents sampled, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each resident and were in accordance with the functional capacity screening	S5155		

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S5155	Continued From page 18 and the negotiated service agreement. Findings included: - Record review for resident #116 revealed an admission date of 7/24/17 and diagnoses of type 2 diabetes mellitus, atrial fibrillation, and hypertension. Functional capacity screen dated 7/21/17 indicated resident required supervision with dressing, toileting, walking with walker, and management of medications; required physical assistance with bathing and transferring; was unable to perform management of medical treatments; and was at risk for falls. Negotiated service agreement/health care service plan (NSA/HCSP) dated 7/24/17 documented health care services of assistance with bathing, toileting, mobility, transferring, and medication; monitor vital signs; and report changes in function and condition. Record contained a medical care provider's order written at the time of resident's admission for blood sugar monitoring 3 times a day and daily weights. Resident's NSA/HCSP lacked the service of blood glucose monitoring and daily weight monitoring and the person responsible for these tasks. At 11:45 a.m. on 12/19/17, operator B provided "Blood Glucose Monitoring" document dated 12/6/17 through the morning of 12/19/17 with columns to record resident's blood sugar reading three times a day. The document contained the following dates, times, and blood sugar readings:	S5155		

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S5155	Continued From page 19 12/6/17 8:00 p.m. 168 12/7/17 7:40 p.m. 226 12/8/17 7:30 p.m. 185 12/9/17 7:50 a.m. 156 and 7:40 p.m. 175 12/10/17 8:20 a.m. 143 and 7:00 p.m. 155 12/11/17 8:00 p.m. 210 12/12/17 7:46 p.m. 126 12/13/17 8:15 p.m. with no blood sugar reading recorded 12/14/17 8:45 a.m. 139 and 7:30 p.m. 168 12/15/17 7:00 p.m. 188 12/16/17 8:25 a.m. 140; 4:45 p.m. 148; and 7:45 p.m. 197 12/17/17 7:50 p.m. 147 12/18/17 8:15 a.m. 143 and 8:00 p.m. 219 12/19/17 7:40 a.m. 141 Certified staff obtained 3 blood sugar readings only on one day. The document lacked the times blood sugar was to be tested. During an interview at 11:45 a.m. on 12/19/17, operator B confirmed the licensed nurse did not coordinate resident's blood sugar monitoring to ensure certified staff performed blood glucose testing consistently 3 times a day and did not designate the time the test to be performed. At 12:10 p.m. on 12/19/17, surveyor observed certified staff F performing blood sugar test with a glucometer for resident #116 in the dining room. At 11:45 a.m. on 12/19/17, operator B also provided 2 vital sign flow sheets dated 11/4/17 through 12/18/17 with a column to record resident's weight. The Vital sign sheets lacked any entries of resident's daily weight. Licensed nurse C stated certified staff members were to record daily weight on the vital signs flow sheet and confirmed certified staff did not document a daily weight. Licensed nurse C stated he/she did	S5155		

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S5155	Continued From page 20	S5155		

not know if certified staff members were obtaining a daily weight of resident.

Record contained written medical care provider's order dated 8/8/17 for laceration staple care, good wound care, watch for signs of infection, and staples out in 7 to 10 days. The order was noted by licensed nurse C. The record lacked documentation of how resident received a scalp laceration.

During an interview at 11:24 a.m. on 12/19/17, licensed nurse C stated resident fell and received a laceration to back of head.

Resident's NSA/HCSP lacked interventions to address resident's risk for falls.

During tour of the facility at 1:23 p.m. on 12/18/17, operator B unlocked a door and stated this was the laundry room area, surveyor observed a small unlocked refrigerator that held 2 plastic bags each with a specimen cup labeled with the name of resident #116 with the date of 11/10/17. One bag was labeled as obtained at 11:35 p.m. and the second bag labeled as obtained at 11:40 p.m. Operator B stated these were stool specimens that were to be sent for lab testing but he/she had forgotten the specimens were in refrigerator.

At 11:55 a.m. on 12/19/17, operator B provided a written medical care provider's order dated 11/8/17 for 3 stool samples to be obtained to test for presence of Clostridium difficile (bacteria that causes inflammation of the colon and diarrhea). Licensed nurse C confirmed the stool specimens were not sent to the lab for testing as ordered by the resident's medical care provider.

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S5155	Continued From page 21 The resident roster indicated resident #116 utilized bed rails. Resident's NSA/HCSP lacked a description of resident use of bed rails, the safety of the bed rail device, and resident's ability to safely use the bed rails. Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #116 and were in accordance with the functional capacity screening and the negotiated service agreement. - Record review for resident #115 revealed an admission date of 12/16/16 and diagnoses of end-stage renal disease, congestive heart failure, and atrial fibrillation. Functional capacity screen dated 12/16/16 indicated resident was unable to perform management of medications and medical treatments; required supervision with bathing, transferring, and walking; and was independent with dressing, toileting, and eating. Negotiated service agreement/health care service plan (NSA/HCSP) dated 12/16/16 documented facility staff to provide meal service; housekeeping; laundry; assistance with bathing, toileting, transferring, and medications; monitor vital signs; and wound care. During an interview at 10:34 a.m. on 12/19/17, certified staff D stated approximately a month ago resident fell out of recliner and had bruising to left side of face. Resident's record lacked documentation of the fall and the bruising. Resident's NSA/HCSP lacked interventions to address resident's risk for falls.	S5155		

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S5155	Continued From page 22 While interviewing resident in the resident's room, surveyor observed bed rails in up position on both sides of the head of the bed. The NSA/HCSP lacked a description of resident's use of bed rails including the safety of the bed rails and resident's ability to safely use the bed rails. During an interview at 1:03 p.m. on 12/19/17, licensed nurse C confirmed the resident's NSA/HCSP lacked interventions to address resident's risk for falls and use of bed rails. Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #115 and were in accordance with the functional capacity screening and the negotiated service agreement. - Record review for resident #117 revealed an admission date of 5/1/17 with diagnoses of history of stroke and dementia. Functional capacity screen dated 4/19/17 indicated resident required supervision with transferring; physical assistance with walking; was at risk for falls; blindness caused by stroke; and experienced impaired short term memory, long term memory, memory recall, and decision making. Negotiated service agreement/health care service plan (NSA/HCSP) dated 5/1/17 documented resident would receive staff assistance with transferring and mobility. The NSA/HCSP lacked interventions to address resident's risk for falls.	S5155		

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S5155	Continued From page 23 During an interview at 10:27 a.m. on 12/19/17, certified staff D stated resident experienced a fall last Thursday (12/14/17). Certified staff D explained that resident had been restless and was sitting on sofa in living room while certified staff D was in another resident's room administering medications. Certified staff D stated that a visitor heard a book shelf fall and found resident (#117) on floor in living room with bookshelf on resident. Certified staff D stated resident received an abrasion to forehead and back of head and a bruise on left lower leg. Certified staff D stated he/she called licensed nurse C who came to the facility to assess the resident. Resident roster documented resident utilized bed rails. NSA/HCSP lacked a description of resident use of bed rails, the safety of the bed rail device, and resident's ability to safely use the bed rails. At 12:40 p.m. on 12/19/17, operator B stated that staff members knew what interventions reduced resident's risk for falls but those interventions were not documented in the resident's NSA/HCSP. Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #117 and were in accordance with the functional capacity screening and the negotiated service agreement.	S5155		
S5161 SS=E	26-42-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed	S5161		

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S5161	Continued From page 24 nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(d) The facility reported a census of 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on record review and interview for 2 (#116, and #117) of 3 residents sampled and 1(#118) of 2 residents focus reviewed, the operator failed to ensure each resident's negotiated service agreement (NSA) contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan (HCSP). Findings included: - Record review for resident #116 revealed an admission date of 7/24/17 and diagnoses of type 2 diabetes mellitus, atrial fibrillation, and hypertension. Functional capacity screen dated 7/21/17 indicated resident was independent with eating; required supervision with dressing, toileting, walking with walker, and management of medications; required physical assistance with bathing and transferring; was unable to perform management of medical treatments; and was at risk for falls. NSA/HCSP dated 7/24/17 documented health care services of assistance with bathing, toileting, mobility, transferring, and medication; monitor vital signs; and report changes in function and	S5161		

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S5161	Continued From page 25	S5161		

condition. The NSA/HCSP lacked the name of the licensed nurse responsible for the implementation and supervision of the nursing plan.

- Record review for resident #117 revealed an admission date of 5/1/17 with diagnoses of history of stroke and dementia.

Functional capacity screen dated 4/19/17 indicated resident required supervision with transferring; physical assistance with bathing, dressing, toileting; mobility, and eating; unable to perform management of medications and medical treatments; was at risk for falls; and experienced impaired short term memory, long term memory, memory recall, and decision making.

NSA/HCSP dated 5/1/17 documented health care services of assistance with eating, bathing, dressing, toileting; transferring, walking, and medications; monitor vital signs; management of behavioral symptoms; and report changes in function and condition.
The NSA/HCSP lacked the name of the licensed nurse responsible for the implementation and supervision of the nursing plan.

- Record review for resident #118 indicated an admission date of 5/29/17 for adult day care services. Record documented resident with a diagnosis of dementia.

Functional capacity screen completed and signed by operator B dated 5/19/17 indicated resident was independent with activities of daily living; unable to perform management of medications and medical treatments; was frequently incontinent of urine; and experienced impaired

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S5161	Continued From page 26 vision and impaired decision making. Operator B did not score the cognition section of the functional capacity screen. NSA/HCSP dated 5/19/17 documented health care service provided by facility staff members of incontinence management. The NSA/HCSP lacked the name of the licensed responsible for implementation and supervision of the nursing plan. During an interview at 12:07 p.m. on 12/19/17, operator B and licensed nurse C each confirmed NSA/HCSP for each resident did not contain the name of the licensed nurse responsible for the implementation and supervision of the HCSP. For resident's #116, #117, and #118, the operator failed to ensure each resident's NSA contained the name of the licensed nurse responsible for the implementation and supervision of the HCSP.	S5161		
S5165 SS=F	26-42-204 (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 26-42-204(e) The facility reported a census of 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed.	S5165		

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S5165	Continued From page 27	S5165		

Based on record review, observation, and interview for 1 (#116) of 3 residents sampled and 1 non-sampled resident (#120), licensed nurse C failed to delegate blood sugar monitoring using a glucometer, a nursing procedure not included in the medication aide curriculum, to medication aides performing the test under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.

Findings included:

- Record review for resident #116 revealed an admission date of 7/24/17 and diagnosis of type 2 diabetes mellitus.

Functional capacity screen dated 7/21/17 indicated resident required supervision with medication management and was unable to perform management of medical treatments.

Negotiated service agreement/health care service plan dated 7/24/17 documented licensed nurse supervised staff members providing medication assistance.

Record contained a medical care provider's order written at the time of resident's admission for blood sugar monitoring 3 times a day.

At 12:10 p.m. on 12/19/17, surveyor observed certified staff F performing blood sugar test with a glucometer for resident #116 in the dining room. Licensed nurse C stated he/she did not instruct each certified staff member on the procedure of blood sugar testing with a glucometer, did not observe each certified staff member perform the procedure, and did not document each staff member's competency. Operator B stated certified staff members also performed blood

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S5165	Continued From page 28 sugar monitoring with a glucometer for resident #120 daily. For resident's #116 and #120, licensed nurse C failed to delegate blood sugar monitoring using a glucometer, a nursing procedure not included in the medication aide curriculum, to medication aides performing the test under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S5165		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(e) The facility reported a census of 5 residents and 2 day care residents. The sample included 3 residents and 2 residents focus reviewed. Based	S5192		

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HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

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S5192	Continued From page 29	S5192		

on interview and record review for all residents, the operator failed to ensure food was prepared using safe methods and served at the proper temperature.

Findings included:

- During tour of the facility kitchen at 1:53 p.m. on 12/18/17, certified staff F stated he/she checked the temperature of meat to make sure chicken cooked to 165 degrees Fahrenheit (F), pork to 150 degrees F, and beef to 150 degrees F but did not measure the temperatures of other foods served to residents. Certified staff F stated he/she did not record the meat temperatures.

At 12:15 p.m. on 12/19/17, observed 5 residents eating lunch in dining room. Resident #115 had lunch taken to his/her room.

At 5:12 p.m. on 12/18/17, operator B stated employees were instructed to only measure the temperature of meat before serving to residents and did not record the temperature. Operator B stated employees did not measure the temperature of all other foods served to residents.

At 4:50 p.m. on 12/19/17, operator B provided the facility policy and procedure for "Food Temperatures at Serving." The policy and procedure instructed staff to serve all hot foods at a temperature of at least 140 degrees F and all cold foods at temperature of 40 degrees F or below. The policy and procedure included instructions for how to measure food temperatures with a metal stem thermometer.

The operator failed to ensure all food was prepared using safe methods and served to

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S5192	Continued From page 30 residents at the proper temperature.	S5192		
S5195 SS=E	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(f) The facility reported a census of 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on observation and interview for all residents, the operator failed to ensure staff stored all food under safe and sanitary conditions. Findings included: - During tour of the facility at 1:23 p.m. on 12/18/17, operator B unlocked a door and stated this was the laundry room area. Surveyor observed a room with a metal shelf that held chemicals and food items. Surveyor also observed an upright freezer. Operator B opened the freezer, located the thermometer, and stated a temperature of -6 degrees Fahrenheit (F). At 1:56 p.m. on 12/18/17, surveyor observed a refrigerator/freezer in the kitchen area. Freezer temperature at -4 degrees F and refrigerator	S5195		

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S5195	Continued From page 31 temperature of 42 degrees F. Operator B stated he/she did not monitor and record refrigerator and freezer temperatures. At 5:12 p.m. on 12/18/17 surveyor returned to the laundry room area with operator B to observe chemicals and food items stored together. The shelves held the following items: Liquid disinfectant Laundry soap Toilet bowl cleaner Lysol disinfectant Fabuloso floor cleaner Clorox urine remover Clorox clean-up spray Dishwasher soap Canned soda Distilled water Rice Canned soup Bottled juices Oatmeal Syrup Coffee Boxes of cereal Canned tuna Peanut butter At 4:50 p.m. on 12/19/17, operator B stated he/she could not locate a food storage policy and procedure. For all residents, the operator failed to ensure staff stored all food under safe and sanitary conditions.	S5195		
S5251 SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents	S5251		

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S5251	Continued From page 32 (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 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on record review and interview for 3 (#115, #116, and #117) of 3 residents sampled, the operator failed to ensure the resident's record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. Findings included: - Record review for resident #115 revealed an admission date of 12/16/16 and diagnoses of end-stage renal disease, congestive heart failure, and atrial fibrillation. Functional capacity screen dated 12/16/16 indicated resident was unable to perform management of medications and medical treatments; required supervision with bathing, transferring, and walking; and was independent with dressing, toileting, and eating. Negotiated service agreement/health care service plan dated 12/16/16 documented facility staff to provide assistance with management of	S5251		

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S5251	Continued From page 33	S5251		

medications and medical treatments including wound care.

Resident's record contained documentation by licensed nurse C to inform resident's medical care provider that resident had developed a one inch by 1/2 inch "sore on right buttock" due to episodes of diarrhea and that resident "is barely mobile at this point." Resident's record lacked documentation of a wound assessment by the licensed nurse, treatment provided, and resident's response to treatment.

Record contained a hospital discharge form that documented resident admitted to hospital on 9/15/17 and discharged back to facility on 9/16/17. Resident's record lacked documentation of reason resident required hospitalization and an assessment by a licensed nurse when resident returned to facility.

During an interview at 10:34 a.m. on 12/19/17, certified staff D stated approximately a month ago resident fell out of recliner and had bruising to left side of face. Resident's record lacked documentation of the fall and the bruising.

During an interview at 1:03 p.m. on 12/19/17, licensed nurse C confirmed resident's record lacked documentation of incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.

The operator failed to ensure the record of resident #115 contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.

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S5251	Continued From page 34 - Record review for resident #116 revealed an admission date of 7/24/17 and diagnoses of type 2 diabetes mellitus, atrial fibrillation, and hypertension. Functional capacity screen dated 7/21/17 indicated resident required supervision with dressing, toileting, walking with walker, and management of medications; required physical assistance with bathing and transferring; was unable to perform management of medical treatments; and was at risk for falls. Negotiated service agreement/health care service plan dated 7/24/17 documented health care services of assistance with bathing, toileting, mobility, transferring, and medication; monitor vital signs; and report changes in function and condition. Record contained written medical care provider's order dated 8/8/17 for laceration staple care, good wound care, watch for signs of infection, and staples out in 7 to 10 days. The order was noted by licensed nurse C. The record lacked documentation of how resident received a scalp laceration, wound care, wound assessments, and the removal of staples from the laceration. During an interview at 11:24 a.m. on 12/19/17, licensed nurse C stated resident fell and received a laceration to back of head. Licensed nurse C took resident to hospital emergency department and resident required 3 staples to close laceration. Licensed nurse C stated he/she removed the staples from the laceration. Licensed nurse C confirmed he/she did not document in the resident's record the fall, injury, action taken, treatment provided, and when	S5251		

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S5251	Continued From page 35 wound healed. The operator failed to ensure the record for resident #116 contained documentation of an incident, the injury including the date, time of occurrence, action taken, and results of the action. - Record review for resident #117 revealed an admission date of 5/1/17 with diagnoses of history of stroke and dementia. Functional capacity screen dated 4/19/17 indicated resident required supervision with transferring; physical assistance with walking; was at risk for falls; blindness caused by stroke; and experienced impaired short term memory, long term memory, memory recall, and decision making. Negotiated service agreement/health care service plan dated 5/1/17 documented resident would receive staff assistance with transferring and mobility. During an interview at 10:27 a.m. on 12/19/17, certified staff D stated resident experienced a fall last Thursday (12/14/17). Certified staff D explained that resident had been restless and was sitting on sofa in living room while certified staff D was in another resident's room administering medications. Certified staff D stated that a visitor heard a book shelf fall and found resident (#117) on floor in living room with bookshelf on resident. Certified staff D stated resident received an abrasion to forehead and back of head and a bruise on left lower leg. Certified staff D stated he/she called licensed nurse C who came to the facility to assess the resident.	S5251		

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S5251	Continued From page 36 At 12:27 p.m. on 12/19/17, licensed nurse C stated he/she did not document the resident's fall and licensed nurse assessment of resident. The operator failed to ensure the record for resident #117 contained documentation of an incident, including the date, time of occurrence, action taken, and results of the action.	S5251		
S5258 SS=E	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced	S5258		

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S5258	Continued From page 37 by: KAR 26-42-102(d)(1)(3) The facility reported a census of 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on record review and interview for 3 of 3 certified employee files reviewed (files of certified employees hired since 8/20/16), operator B failed to ensure each file contained documentation from the Kansas nurse aide registry (obtained prior to each certified staff providing resident care), of certification and that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home. Findings included: - Review of employee files with operator B at 2:15 p.m. on 12/19/17 revealed the following: Certified staff D hired 9/25/17 without documentation from the Kansas nurse aide registry. Certified staff E hired 7/21/17 without documentation from the Kansas nurse aide registry. Certified staff F hired 8/25/17 with documentation from the Kansas nurse aide registry. The documentation lacked a date to indicate operator B confirmed evidence of certification and no findings of abuse, neglect, or exploitation of a resident in an adult care home prior to employee providing care to residents. At 2:21 p.m. on 12/19/17, operator B checked the on-line Kansas nurse aide registry for certified staff D and E and printed the required form for	S5258		

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S5258	Continued From page 38 each employee. Operator B stated he/she did check the Kansas nurse aide registry when these employees were hired but did not print the forms at that time. Operator B failed to ensure each employee file contained documentation from the Kansas nurse aide registry (obtained prior to each certified staff providing resident care), of certification and that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home.	S5258		
S5265 SS=D	26-42-205 (a) (1) Medication Self Administration Assessment (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by:	S5265		

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S5265	Continued From page 39 KAR 26-42-205(a)(1) The facility reported a census of 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on record review and interview for 1 (#115) of 3 residents sampled, a licensed nurse failed to perform an assessment of the resident's ability to safely and accurately self-administer a medication without staff assistance before the resident began self-administration. Findings included: - Record review for resident #115 revealed an admission date of 12/16/16 with diagnoses of end stage renal disease, congestive heart failure, and atrial fibrillation. Functional capacity screen dated 12/16/16 indicated resident was unable to perform management of medications and medical treatments. Negotiated service agreement/health care service plan dated 12/16/16 documented service of medication assistance. The December 2017 medication administration record (MAR) documented resident to receive Triamcinolone topical 0.5% (a topical steroid to treat skin inflammation) two times a day. The MAR lacked initials of certified or licensed staff members to indicate resident received the medication. During an interview at 12:50 p.m. on 12/19/17, operator B stated resident kept the Triamcinolone in his/her room and self-administered. Licensed nurse C stated he/she did not perform an	S5265		

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S5265	Continued From page 40 assessment of the resident's ability to safely and accurately self-administer the medication. The licensed nurse failed to perform an assessment of the resident #115's ability to safely and accurately self-administer a medication without staff assistance before the resident began self-administration.	S5265		
S5286 SS=D	26-42-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(b) The facility reported a census of 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on record review and interview for 1 (#115) of 3 residents sampled, the operator failed to ensure the negotiated service agreement documented resident self-administered a medication. Findings included: - Record review for resident #115 revealed an	S5286		

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S5286	Continued From page 41 admission date of 12/16/16 with diagnoses of end stage renal disease, congestive heart failure, and atrial fibrillation. Functional capacity screen dated 12/16/16 indicated resident was unable to perform management of medications and medical treatments. Negotiated service agreement/health care service plan dated 12/16/16 documented service of medication assistance. The December 2017 medication administration record (MAR) documented resident to receive Triamcinolone topical 0.5% (a topical steroid to treat skin inflammation) two times a day. The MAR lacked initials of certified or licensed staff members to indicate resident received the medication. During an interview at 12:50 p.m. on 12/19/17, operator B stated resident kept the Triamcinolone in his/her room and self-administered. Operator B confirmed the negotiated service agreement documented staff members administered medications to resident and did not specify resident self-administered a medication. The operator failed to ensure the negotiated service agreement documented resident #115 self-administered a medication.	S5286		
S5300 SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the	S5300		

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S5300	Continued From page 42 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 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on record review and interview for 2 (#115 and #116) of 3 residents sampled, the operator failed to ensure all medications and biologicals were administered to each resident in accordance with a medical care provider's written order and professional standards of practice. Findings included: - Record review for resident #115 revealed an admission date of 12/16/16 with diagnoses of end stage renal disease, congestive heart failure, and atrial fibrillation. Functional capacity screen dated 12/16/16 indicated resident was unable to perform management of medications and medical	S5300		

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(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
S5300	Continued From page 43 treatments. Negotiated service agreement/health care service plan dated 12/16/16 documented medication assistance by facility staff The medical care provider order section of the resident record contained a list of medications dated 9/15/17 of resident to receive after hospital discharge on 9/16/17. The medication list was not signed by a medical care provider. Comparison of resident's December 2017 medication administration record (MAR) with this list revealed certified medication aides and a licensed nurse administered the following medications without a signed medical care provider's order: Famotidine (to treat gastroesophageal reflux disease) 20 milligrams (mg) by mouth daily before meal Cholecalciferol (supplement) 1000 international units by mouth daily Folic acid (supplement)1 mg by mouth daily Ropinirole (to treat restless leg syndrome)1 mg by mouth 3 times a day Ferrous sulfate (supplement) 325 mg 1 tablet daily Pravachol (used to lower cholesterol levels) 40 mg by mouth daily Melatonin (supplement) 10 mg by mouth daily Donepezil (to treat dementia) 5 mg by mouth daily Docusate sodium (stool softener) 100 mg by mouth two times a day as needed Acetaminophen (pain reliever/fever reducer) 325 mg 2 tablets every 4 hours as needed Zofran (to relieve nausea) 4 mg by mouth every 4 hours as needed Lidocaine (to relieve pain) 5% adhesive patch apply 1 patch daily, remove after 12 hours Triamcinolone (to treat skin inflammation) topical	S5300		

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	B088002	A. BUILDING: _____ B. WING _____	12/27/2017

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S5300	Continued From page 44 0.5% apply topically to affected area two times a day During an interview at 12:37 p.m. on 12/19/17, licensed nurse C confirmed the above medications were administered to the resident without a signed medical care provider's order. The December 2017 MAR contained entries for the following medications without a signed medical care provider's order: Azithromycin (antibiotic) 500 mg for 7 days. Resident received this medication 12/12/17 through 12/18/17. Sertraline (to treat depression) 100 mg by mouth daily Omeprazole (to treat gastroesophageal reflux disease) 40 mg by mouth daily Imodium 2 tablets by mouth after first episode of diarrhea and 1 tablet after each subsequent episode of diarrhea as needed Zofran (to relieve nausea) 8 mg by mouth every 8 hours as needed Betamethasone (topical steroid to relieve inflammation) 0.12% foam to scalp daily at bedtime and rinse in morning Albuterol Sulfate syrup 1 teaspoon by mouth every 4 to 6 hours as needed for cough Licensed nurse C unable to provide written and signed medical care provider's order for these medications. The operator failed to ensure all medications and biologicals were administered to resident #115 in accordance with a medical care provider's written order and professional standards of practice. - Record review for resident #116 revealed an admission date of 7/24/17 and diagnoses of type	S5300		

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S5300	Continued From page 45 2 diabetes mellitus, atrial fibrillation, and hypertension. Functional capacity screen dated 7/21/17 indicated resident required supervision of medication management and was unable to perform management of medical treatments. Negotiated service agreement/health care service plan dated 7/24/17 documented medication assistance by facility staff. Resident's record contained a written and signed medical care provider order dated 12/13/17 for Coumadin (used to prevent blood clot formation) 7.5 milligrams (mg) daily by mouth for 6 days and Coumadin 2 mg on 7th day. The December 2017 medication administration record (MAR) contained documentation resident received Coumadin 7.5 mg on 12/14/17, 12/15/17, 12/16/17, and 12/17/17 (4 days). The MAR contained only these dates open for staff to administer this dose of Coumadin and an open box for resident to receive Coumadin 2 mg on 12/18/17. During an interview at 11:30 a.m. on 12/19/17, licensed nurse C stated he/she made a mistake when indicating on the MAR the dates resident to receive Coumadin 7.5 mg. Operator B stated licensed nurse G administered Coumadin 2 mg the evening of 12/18/17. The MAR contained the following medications that lacked a written and signed medical care provider's order: Flonase nasal spray (to treat nasal congestion caused by allergies) 1 spray each nostril two times a day Imodium 2 tablets by mouth after first loose stool	S5300		

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S5300	Continued From page 46 and one tablet after next loose stool Tessalon perles (to control cough) 100 mg 1 or 2 tablets by mouth every 8 hours The MAR contained an entry for Digoxin (to slow heart rate for resident with atrial fibrillation) 0.125 mg to be given by mouth daily and to hold medication if heart rate less than 60 beats per minute. The MAR contained initials of staff members to indicate resident received the medication daily 12/1/17 through 12/18/17. Staff members did not record resident's heart rate on December 1, 3, 5, 6,7, 8, 11, 12, 15, and 17, 2017. Per interview at 11:45 a.m. on 12/19/17, operator B confirmed certified staff members did not document resident's heart rate on the MAR prior to administration of Digoxin. The operator failed to ensure all medications and biologicals were administered to resident #116 in accordance with a medical care provider's written 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	S5301		

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S5301	Continued From page 47 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. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(3)(D) The facility reported a census of 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on record review and interview for 3 (#115, #116, and #117) of 3 residents sampled, operator failed to ensure certified medication aides and licensed nurses documented on the medication administration record the actual clock time scheduled medications were administered to residents. Findings included: - Record review for resident #115 revealed an admission date of 12/16/16 with diagnoses of end stage renal disease, congestive heart failure, and atrial fibrillation. Functional capacity screen dated 12/16/16 indicated resident was unable to perform management of medications and medical treatments. Negotiated service agreement/health care service plan dated 12/16/16 documented service of medication assistance and management of oxygen therapy and breathing treatments.	S5301		

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S5301	Continued From page 48 Review of the December 2017 medication administration record (MAR) revealed administration of scheduled medications as given A.M., P.M.; and H.S. (hour of sleep). Ropinirole (to treat restless leg syndrome) 1 milligram by mouth 3 times a day documented on the MAR to be given A.M., 2:00 p.m., and H.S. Certified medication aides (CMAs) and licensed nurse did not document actual clock time medications were administered to the resident. - Record review for resident #116 revealed an admission date of 7/24/17 with diagnoses of type 2 diabetes mellitus, hypertension, and atrial fibrillation. Functional capacity screen dated 7/21/17 indicated resident required supervision for management of medications and was unable to perform management of medical treatments. Negotiated service agreement/health care service plan dated 7/24/17 documented service of medication assistance. Review of the December 2017 MAR revealed administration of scheduled medications as given A.M., P.M.; and H.S. CMAs and licensed nurse did not document actual clock time medications were administered to the resident. - Record review for resident #117 revealed an admission date of 5/1/17 with diagnoses of history of stroke and dementia. Functional capacity screen dated 4/19/17 indicated resident was unable to perform management of medications and medical treatments.	S5301		

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S5301	Continued From page 49 Negotiated service agreement/health care service plan dated 5/1/17 documented service of medication assistance. Review of the December 2017 MAR revealed administration of scheduled medications as given A.M. And H.S. CMAs and licensed nurse did not document actual clock time medications were administered to the resident. During an interview at 11:30 a.m. on 12/19/17, licensed nurse C confirmed CMAs and licensed nurse did not document the actual clock time each resident received a scheduled medication. Interview at 11:45 a.m. on 12/19/17, operator B stated CMAs and licensed nurse documented actual clock time only for those medications given on an as needed basis. Operator failed to ensure certified medication aides and licensed nurses documented on the medication administration record the actual clock time scheduled medications were administered to residents #115, #116, and #117.	S5301		
S5315 SS=E	26-42-205 (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 managed by the home in a locked medication	S5315		

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S5315	Continued From page 50 room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home 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 home. (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 26-42-205(h)(1) The facility reported a census of 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on observation, record review, and interview for all residents, the operator failed to ensure refrigerated medications and medications to be destroyed were accessible only to certified medication aides and licensed nurses authorized to administer medications. Findings included:	S5315		

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S5315	Continued From page 51 - During tour of the facility at 1:23 p.m. on 12/18/17, operator B unlocked a door and stated this was the laundry room area. Surveyor observed a room with a metal shelf with a large plastic tub on the bottom shelf. The plastic tub held numerous medication bottles and packages. Operator stated these were medications waiting to be destroyed. Surveyor observed a small refrigerator on a shelf that was not locked. Operator stated this refrigerator was used to store medications that required refrigeration. Surveyor observed an open bottle of tuberculosis skin testing solution with open date of 9/26/17, 6 Novolog insulin pens, and 6 Levemir insulin pens. Operator B confirmed the tuberculosis testing solution was outdated and stated the insulin pens belonged to a resident dismissed the end of April 2017. Review of the facility personnel list revealed not all employees were certified medication aides or licensed nurses. During an interview at 2:31 p.m. on 12/19/17, operator B confirmed the medications stored in the laundry room area were accessible to employees not authorized to administer medications. The operator failed to ensure refrigerated medications and medications to be destroyed were accessible only to certified medication aides and licensed nurses authorized to administer medications.	S5315		
S5316 SS=E	26-42-205 (i) Disposition of Medication (i) Accountability and disposition of medications.	S5316		

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S5316	Continued From page 52 Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(i) The facility reported a census of 5 residents and 2 adult day care residents. The sample included 3 residents and 2 residents focus reviewed. Based on observation, interview, and record review for 1 (#115) of 3 residents sampled, 1 (#119) of 2 residents focus reviewed, 2 (#121 and #122) discharged residents, 3 (#123, #124, #125) deceased residents, and 3 (#126, #127, #128)	S5316		

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S5316	Continued From page 53	S5316		

residents not listed on resident roster, discharged, or deceased, the operator failed to ensure licensed nurses and medication aides maintained records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation.

Findings included:

- During tour of the facility at 1:23 p.m. on 12/18/17, operator B unlocked a door and stated this was the laundry room area. Surveyor observed a room with a metal shelf with a large plastic tub on the bottom shelf. The plastic tub held numerous medication bottles and packages. Operator stated these were medications waiting to be destroyed. Surveyor observed a small refrigerator on a shelf that was not locked. Operator stated this refrigerator was used to store medications that required refrigeration. Surveyor observed 6 Novolog insulin pens, and 6 Levemir insulin pens with pharmacy labels for resident #122. Operator B stated the insulin pens belonged to (resident #122) dismissed the end of April 2017.

At 2:15 p.m. on 12/18/17, operator B removed the medications to be destroyed from the plastic tub. Surveyor observed the following:

Sampled resident #115 with 7 medications.

Focus reviewed resident #119 with 4 medications. Operator B listed this resident deceased 11/20/17.

Non-sampled residents:

#121 listed as discharged 5/4/17 with 4 medications.

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S5316	Continued From page 54 #122 listed as discharged 4/25/17 with 15 medications. #123 listed as deceased 11/19/17 with 2 medications. #124 listed as deceased 10/22/17 with 2 medications. #125 listed as deceased 9/28/17 with 8 medications. #126 not listed as discharged or deceased with 1 medication. #127 not listed as discharged or deceased with 3 medications. #128 not listed as discharged or deceased with 10 medications. At 3:28 p.m. on 12/18/17, surveyor observed liquid morphine (pain relief), topical lorazepam (anti-anxiety), and Ambien (for sleep)tablets for deceased resident #119. Licensed nurse G stated these medications to be destroyed. Review of the facility's "Destruction of Drugs and Biologicals" revealed controlled medications to be destroyed by two licensed nurses or a licensed nurse and pharmacist. Policy and procedure did not specify employees responsible to destroy non-controlled medications or a timeframe for medications to be destroyed. Review of a completed "Medication Disposal Log" provided by operator B at 3:15 p.m. on 12/18/17 revealed licensed nurse C and licensed nurse G destroyed 11 controlled medications. The form included the name of the resident, the name and strength of	S5316		

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S5316	Continued From page 55 each medication, the prescription number, the amount destroyed, method of disposal, reason for disposal, and the signature of each licensed nurse. The form included a column for the date each medication was destroyed but neither licensed nurse documented the date. During an interview at 11:25 a.m. on 12/19/17, licensed nurse C stated he/she and operator B destroyed medications last evening. Licensed nurse C stated "We need to make it a policy to (destroy) medications every quarter or every month." Operator B failed to ensure licensed nurses and medication aides maintained records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation.	S5316		