STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	08/14/2017

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ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

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S 000	INITIAL COMMENTS The following citations are the result of a Licensure Resurvey at the above named Assisted Living Facility in Abilene, Kansas on 8/08/17, 8/09/17, and 8/14/17. Revised 2567 sent to facility 8/21/2017	S 000		
S3101 SS=D	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The census equalled 24 the sample included three Residents. Based on reviews of records and interviews, for one of three sampled (#189), the Operator failed to ensure each individual involved in the development of the negotiated service agreement/health service plan (NSA/HSP) signed the agreement. Findings included: - Review of record revealed #189 admitted to facility 6/26/14 with diagnoses of Congestive heart failure, Hypertension, and Coronary artery disease. The current functional capacity screen of 7/30/17 assessed #189 independent with with bathing, dressing, toileting, transfers, mobility, and eating;	S3101		

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

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S3101	Continued From page 1 in need of physical assistance with medication and treatment management; occasional bladder continence; with decision making impaired, falls/unsteadiness, and used a cane and walker. The record contained an NSA/HSP with date completed "7/30/17." This NSA/HSP lacked signature of the Resident or the Resident's legal representative. The NSA/HSP contained the signature of the Facility Nurse #G 7/30/17, and signature of the Operator 8/04/17. The record lacked evidence of attempts to obtain the signature of the Resident or the legal Representative. On 8/10/17 at 2:58pm Facility Nurse #G and Consultant Nurse #H confirmed the NSA/HSP lacked signatures of the Resident or the responsible party... also lacked evidence of attempts to obtain the signatures... #H stated Operator signed after I did because he/she was out of town... I haven't had contact with the family member yet to review, read, or sign the NSA/HSP... Record review revealed an additional NSA/HSP completed 4/26/17. This NSA/HSP signed by previous Facility Nurse on 4/26/17; signed by Operator and Resident's representative on 5/01/17. The Operator failed to ensure each individual involved in the development of the NSA/HSP for #189 signed the agreement.	S3101		
S3175 SS=E	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any	S3175		

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S3175	Continued From page 2 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: KAR 26-41-205(a)(1) The census equalled 24 the sample included three Residents. The facility identified eight Residents who self administered medications, none of these included in the sample. Based on observation, interview, and review of record, for three of three sampled who self administered medications (#185, #187, and #189), the Operator failed to ensure a licensed nurse performed an assessment of the Resident's ability to safely and accurately self administer medications. Findings included: - Review of record revealed #185 admitted to facility 5/05/17 with diagnoses of Dementia and Chronic gait instability.	S3175		

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S3175	Continued From page 3 The current 4/13/17 functional capacity screen (FCS) assessed #185 in need of medication and treatment services (coded with a check mark, not identified in the functional capacity screen manual as an assessment code). The current 5/05/17 negotiated service agreement (NSA) documented facility to provide medication management "required staff assistance with administering, storing and ordering medication...#185 does over the counter muninex (sic) and applies Vasoline (sic) to his/her body." The medical record contained a 5/10/17 order for Mucinex twice daily as needed, and a 5/05/17 order for Vaseline petroleum jelly apply after showers as needed. The MAR (medication administration record) of 7/10/17 through 8/09/17 recorded each medication, and documented administration of Mucinex by staff on five dates. On 8/10/17 at 4:13pm Facility Nurse #G and Consultant Nurse #H confirmed the NSA recorded #185 self administered medications... confirmed the medical record lacked a self administration assessment. The Operator failed to ensure a licensed nurse conducted a self administration assessment of #185 prior to #185 self administering medications. - Review of record revealed #187 admitted to facility 01/13/17 with diagnoses of Hypertension, Heart failure, Syncope, Cachexia, Hyperparathyroidism, Asthenia, Diabetes mellitus,	S3175		

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S3175	Continued From page 4 Constipation, Rhabdomyolosis, and Tendonitis. The current 01/13/17 functional capacity screen (FCS) assessed #187 in need of physical assistance with medication management, and unable to perform treatment management. The current 01/13/17 negotiated service agreement (NSA) documented facility to provide medication management "staff is to administer his/her medications... takes I-Vite tablet by mouth once daily... also takes an antacid daily for indigestion." By observation on 8/10/17 at 11:55am, bottle of Tums antacid on bedside table in room. The medical record contained 01/16/17 orders for Ocuvite daily and for Antacid (Tums) every two to four hours as needed for indigestion. The MAR (medication administration record) of 7/10/17 through 8/09/17 recorded each medication, and documented administration of Ocuvite daily by staff. On 8/10/17 at 3:37pm Facility Nurse #G and Consultant Nurse #H confirmed the medical record lacked a self administration assessment. The Operator failed to ensure a licensed nurse conducted a self administration assessment of #187 prior to #187 self administering medications. - Review of record revealed #189 admitted to facility 6/26/14 with diagnoses of Congestive heart failure, Hypertension, and Coronary artery disease.	S3175		

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S3175	Continued From page 5 The current 9/07/16 functional capacity screen (FCS) assessed #189 in need of physical assistance with medication and treatment management. The current 7/30/17 negotiated service agreement (NSA) documented facility to provide medication management "facility will be responsible for ordering, storing, and administering medications." The medical record contained 6/12/17 orders for Vicks Vapor rub (nose stick) and a jar of it if all possible (at bedside) for his/her congestion." The MAR (medication administration record) of 7/10/17 through 8/09/17 recorded Vicks Vaporub ointment... may keep at bedside for congestion. On 8/10/17 at 2:58pm Facility Nurse #G and Consultant Nurse #H confirmed the medical record lacked a self administration assessment. The Operator failed to ensure a licensed nurse conducted a self administration assessment of #189 prior to #189 self administering medications.	S3175		
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 provider ' s written order, professional standards	S3200		

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S3200	Continued From page 6 of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(1-2) The census equalled 24 the sample included three Residents. The facility identified 16 Residents as receiving medication management. Based on interviews and reviews of records, for two of three sampled (#187 and #189), the Operator failed to ensure all medications and biologicals administered in accordance with a medical provider's written orders and in accordance with professional standards. Findings included: - Review of record revealed #189 admitted to facility 6/26/14 with diagnoses of Congestive heart failure, Hypertension, and Coronary artery disease. The current 9/07/16 functional capacity screen (FCS) assessed #189 in need of physical assistance with medication and treatment management. The current 7/30/17 negotiated service	S3200		

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S3200	Continued From page 7	S3200		

agreement (NSA) documented facility to provide medication management "facility will be responsible for ordering, storing, and administering medications."

The MAR (medication administration record) of 7/10/17 through 8/09/17 contained an order dated 6/02/17 for Plavix (anticoagulation) 75mg (milligrams) by mouth every day for 60 days. The MAR documented the Plavix administered daily at 5:00pm, with documentation the medication not administered on 8/01/17, 8/02/17, and 8/03/17.

The medical record contained physician (cardiologist) communication notes.
The first note dated 8/04/17 at 4:35pm "facility called asking for clarification on patient's Plavix. How long is he/she to continue it?"
This second note contained additional communication on 8/04/17 at 11:21am "facility called again stating they are holding Plavix until they get further clarification."
The third note on 8/04/17 at 11:42am from physician "he/she is supposed to take it for 6 months."
A fourth hand written note by the cardiologist on 8/07/17 recorded: "the patient is supposed to take Aspirin and Plavix for 6 months. Do Not hold any medication except if there is a bleeding issue without clarifying with me first. The decision to keep on the Aspirin and Plavix was sent also to the primary care office after his/her procedure."

Resident service notes of record included:
8/02/17 at 1412 - notified APRN (advanced practice registered nurse) that Resident has completed 60 day order of Plavix. Nurse asked if would like Resident to continue or discontinue, awaiting orders.
8/03/17 at 1755 - APRN's nurse called... stated

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S3200	Continued From page 8 Resident should have orders to continue Plavix for three months from 6/02/17... does not have this order... cardiologist notified with message left... 8/04/17 at 2125 - received order on 8/04/17 supposed to take Plavix for 6 months per cardiologist... The original Plavix order of 6/02/17 contained a note for refills. The record lacked evidence the physician contacted prior to holding the medication on 8/01/17 through 8/03/17. On 8/10/17 at 2:58pm Facility Nurse #G and Consultant Nurse #H confirmed the medical record lacked evidence the medication clarification obtained prior to holding an anticoagulation medication for this Resident. The Operator failed to ensure all medications and biologicals administered to #189 in accordance with written medical care provider orders and in accordance with professional standards. - Review of record revealed #187 admitted to facility 01/13/17 with diagnoses of Hypertension, Heart failure, Syncope, Cachexia, Hyperparathyroidism, Asthenia, Diabetes mellitus, Constipation, Rhabdomyolosis, and Tendonitis. The current 01/13/17 functional capacity screen (FCS) assessed #187 in need of physical assistance with medication management, and unable to perform treatment management. The current 01/13/17 negotiated service agreement (NSA) documented facility to provide medication management.	S3200		

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S3200	Continued From page 9	S3200		

The MAR (medication administration record) of 7/10/17 through 8/09/17 recorded an order for Omeprazole 20mg (milligrams) by mouth every morning. Documentation of administration failed to meet professional standards of practice. According to Mayoclinic.org, this medication should be taken on an empty stomach prior to breakfast.
MAR documentation revealed Omeprazole administered at the same time as all other am medications and not on empty stomach, 1/2 hour prior to other medications or breakfast. (Other medications included: Lisinopril for blood pressure, Ocuvite multi vitamin, Amlodipine for blood pressure, Carvedilol for blood pressure, Fluoxetine for depression, Januvia for diabetes, and Ranitidine for gastric acid.

In addition, the MAR recorded an order for Ranitidine 150mg (milligrams) by mouth twice daily dated 7/12/17.
The record contained a prior order for Ranitidine 150mg twice daily on 01/23/17.
The Resident Progress Notes of 01/24/17 documented to stop morning dose of Ranitidine, and although the MAR's of April through July 2017 reflected once daily dosing, the order to change from twice daily to daily not located.
A new order received on 6/29/17 recorded: Ranitidine 150mg quantity 30 tablets (crossed out and 60 written in) take one tablet twice a day by oral route.
The MAR of 7/10/17 through 8/09/17 recorded the twice daily dose not started until 7/12/17.

By interview on 8/10/17 at 3:37pm Facility Nurse #G and Consultant Nurse #H confirmed the medical record lacked clear orders for changes of the Ranitidine... confirmed the most recent order for twice daily on 6/29/17 started on the MAR on

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S3200	Continued From page 10 7/12/17... On 8/10/17 at 4:30pm, Facility Nurse #G stated I was waiting for clarification... honestly just went ahead and started at twice daily since I never heard from them 6/29/17 after appointment at the office... The Operator failed to ensure all medications and biologicals administered to #187 in accordance with written medical care provider orders and in accordance with professional standards.	S3200		