STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N075007	A. BUILDING: _____ B. WING _____	06/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBUD PLAZA ASSISTED LIVING	205 WEST 9TH STREET ONAGA, KS 66521

(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
S 000	INITIAL COMMENTS the following citations are the result of a licensure re-survey at the above named assisted living facility in Onaga, KS on 6/19/17, 6/20/17 and 6/21/17.	S 000		
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 of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 24 residents. The sample included 3 residents and 1 focus review resident. Based on record review, observation and interview for 1 (#621) sampled resident and 3 non-sampled residents (#623, 624 and 625), the operator failed to ensure that medications were administered to residents	S3200		

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

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S3200	Continued From page 1 according to professional standards of practice when the licensed nurse failed to assess the resident's ability to self-inject insulin. Findings included: - Record review for resident #621 recorded an admission date of 4/26/16 with diagnoses of: diabetes mellitus type1, dermatitis, glaucoma, hypercholesterolemia, heart disease, and gout. Functional Capacity Screen dated 4/21/17 recorded resident required assistance with management of medications and treatments. Negotiated service agreement/ health care service plan dated 4/21/17 recorded facility staff is responsible for medication management and diabetes management; resident will self-administer insulin from flex pens. June 2017 MAR (medication administration record) recorded the following insulins (diabetes) as administered by facility staff June 1 - June 18th: Novo log flex pen solution pen-injector 100 unit/ml (units per milliliter) injects 13 units (SQ) subcutaneously in the morning with breakfast; Novolog flex pen solution pen injector 100 unit/ml injects 10 units SQ two times every day with lunch and dinner; Tresiba flex touch solution Pen- injector 100 unit/ml inject 30 units SQ at bedtime. Interview on 6/20/17 at 1:35pm with resident confirmed he/she self- injects the insulin after staff dials the insulin pens.	S3200		

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S3200	Continued From page 2 Interview on 6/20/17 at 1:00pm with licensed nurse #B confirmed resident takes insulin 3 times a day, and record lacked documentation of a self-administration assessment for insulin injection for resident. Resident roster recorded 4 residents who receive insulin injections. Interview on 6/19/17 at 4:55pm with facility operator #A confirmed all 4 diabetics self-inject insulin and records lacked assessments for ability to self-inject insulin on all 4 residents. For resident #621, 623, 624, 625, who self- inject insulin the operator failed to ensure that medications were administered to residents according to professional standards of practice when the licensed nurse failed to assess the resident's ability to self-inject insulin.	S3200		
S3201 SS=E	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only	S3201		

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S3201	Continued From page 3	S3201		

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 26-41-205(d) (3) (D)

The facility reported a census of 24 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1sampled resident (#619) and 1 focus review resident (#622) requiring medication administration the operator failed to ensure the medication aide remained with the resident until the medication is ingested or applied.

Findings included:

- Record review for resident #619 recorded an admission date of 4/4/01 with diagnoses of: rheumatic disorder of mitral and aortic valves, gastroesophogeal reflux disease (GERD), hypothyroidism, hyperlipidemia, allergic rhinitis, osteoarthritis and major depressive disorder.

Functional Capacity Screen (FCS) dated 3/24/17 recorded resident unable to perform management of medications and treatments.

Negotiated service agreement/ health care service plan (NSA/HCSP) dated 3/22/17 recorded facility to administer medications and treatments, resident will have unsupervised self-administration of Tylenol during the night hours. Resident prefers to take at approximately 2am.

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S3201	Continued From page 4 June 2017 MAR (medication administration record) recorded resident received Tylenol (pain) extra strength tablet 500 mg (milligrams) by mouth at bedtime June 1- June 18th, initialed as administered by facility staff. Observation on 6/19/17 at 10:15am in facility medication cart revealed 2 blue pill minder boxes, empty. Interview on 6/19/17 at 10:15am with certified staff #C stated the evening CMA (certified medication aide) sets up the HS (bedtime) medications and also a 2am medication in the boxes and leave them on the residents' kitchen table or counter and resident takes the medications themselves. Interview on 6/20/17 at 11:25am with licensed nurse #B confirmed staff (CMA) places resident dose of Tylenol in the pill minder box and leaves it in the resident's room for resident to take later, about 2am. CMAs failed to observe the resident ingest a medication they prepared. Record review for resident #622 recorded admission date of 4/4/01 with diagnose of: atrial fibrillation, constipation, chronic fatigue, hypertension, gout, hyperlipidemia and osteoarthritis. FCS dated 3/24/17 recorded resident as unable to perform management of medications and treatments. NSA/HCSP dated 3/22/17 recorded facility to administer medications and treatments, resident	S3201		

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S3201	Continued From page 5	S3201		

will have unsupervised self- administration of Tylenol during the night hours. Resident prefers to take at approximately 2am.

June 2017 MAR recorded Tylenol (pain) tablet 325mg, give 650mg by mouth at bedtime, may have in pill box for overnight use at 2am and Xopenex Nebulization (respiratory) solution 1.25mg/3ml (milligrams/ milliliter) 1 unit inhale orally via nebulizer 3 times a day. Both medications initialed as administered by staff June 1-June 18th.

Medication self-administration assessment dated 10/25/16 recorded resident will self-administer maxi mist (MMTX) treatment as set up by CMA or LPN/RN (licensed practical nurse/ registered nurse and resident will self- administer Tylenol at 2am or as requested by resident.

Interview on 6/19/17 at 10:15am with certified staff #C stated the evening CMA (certified medication aide) sets up the HS (bedtime) medications and also a 2am medication in the boxes and leave them on the residents' kitchen table or counter and resident takes the medications themselves.

Interview on 6/20/17 at 11:25am with licensed nurse #B confirmed staff (CMA) places resident dose of Tylenol in the pill minder box and leaves it in the resident's room for resident to take later, about 2am and sets up resident's nebulizer treatment and resident takes it later.

CMAs failed to observe the resident ingest medications and treatments they prepared.

For residents #619 and #622 who required medication administration, the operator failed to

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S3201	Continued From page 6 ensure the medication aide remained with the resident until the medication is ingested or applied.	S3201		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f) (11) The facility reported a census of 24 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1sampled residents (#619) the operator failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action. Findings included: - Record review for resident #619 recorded an admission date of 4/4/01 with diagnoses of: rheumatic disorder of mitral and aortic valves, gastroesophogeal reflux disease (GERD),	S3261		

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S3261	Continued From page 7	S3261		

hypothyroidism, hyperlipidemia, allergic rhinitis, osteoarthritis and major depressive disorder.

Functional Capacity Screen (FCS) dated 3/24/17 recorded resident unable to perform management of medications and treatments. Resident has a history of falls/unsteadiness. Resident has no problems with cognition or communication.

Negotiated service agreement/ health care service plan (NSA/HCSP) dated 3/22/17 recorded facility to administer medications and treatments.

Resident roster received 6/19/17 recorded resident fell on 1/3/17.

Resident progress notes contained nursing entries for 7/7/16 at 12:05pm (resident asks about losing weight) and 5/4/17 (foot care provided today).

72 hour post fall review dated 1/3/17 at 9:51am recorded resident vital signs, range of motion and skin assessment.

Interview on 6/20/17 at 11:55am with facility operator #A stated resident fell outside of facility, he/she is unsure as he/she was not working that day, confirmed record lacked entry for fall, incident report was completed but was sent to the main office and cannot be obtained.

Record lacked nursing entry for resident fall including location of fall, resident account of fall, physician and family notification of fall and follow up documentation of fall including fall interventions.

For resident #619 the operator failed to ensure documentation of all incidents, and indications of

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S3261	Continued From page 8 illness or injury including date, time of occurrence, action taken and results of the action.	S3261		