STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	04/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

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S 000	INITIAL COMMENTS The following citations represent the findings of resurvey at the above named home plus facility on 4-5-17, 4-6-17, 4-10-17, 4-17-17, 4-18-17, and 4-19-17.	S 000		
S5080 SS=E	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) The facility identified a census of 8 residents. The sample included 3 residents. Based on record review, interview, and observation for 2 (#222 and #333) of 3 residents sampled, the owner/operator/RN failed to ensure a Functional Capacity Screen (FCS) conducted on or before admission to facility.	S5080		

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

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S5080	Continued From page 1 Findings included: - Record review for resident #222 revealed admit date of 2-17-17 with diagnoses of dementia, Parkinson ' s, anxiety, and high risk of falls. The record lacked a FCS. Interview on 4-6-17 at 11:55 a.m. with owner/operator/RN stated and confirmed resident record lacked a FCS upon surveyor's arrival. - Record review for resident #333 revealed admit date of 4-4-17 with diagnoses of post-polio syndrome, Alzheimer ' s muscle weakness, osteoarthritis, anxiety, and hypertension. The record lacked a FCS when reviewed at 10:30 a.m. and received at approximately 11:00 a.m. dated 4-6-17 recorded resident required physical assistance with transfer, toileting, unable to assist with walking/mobility, experienced memory recall, decision making, impaired decision making, impaired hearing, and falls/unsteadiness. Interview on 4-6-17 at 2:00 p.m. with licensed nurse/operator B stated and confirmed a FCS had not been conducted at this time. For residents #222 and #333, the owner/operator/RN failed to ensure a FCS conducted on or before admission to facility.	S5080		
S5205 SS=L	26-42-104 (a) Disaster and Emergency Preparedness a) The administrator or operator of each home plus shall ensure the provision of a sufficient	S5205		

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S5205	Continued From page 2 number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(a) The facility identified a census of 8 residents. The sample included 3 residents. Based on record review, interview, and observation for 2 (#111, #333) of 3 residents sampled and 1 (#400) of 5 non sampled residents who required a two person assist using sit to stand lift/hoyer lift for transfer and 1 (#222) of 3 sampled, 1 (#401) 5 non-sampled residents who required staff directions due to wandering and dementia, the owner/operator/Registered Nurse (RN) failed to ensure a sufficient number of staff members to take all residents to a secure location in an emergency or disaster when only 2 certified staff were scheduled to work from 6 p.m. to 6 a.m. This deficient practice placed all residents in immediate jeopardy for harm or death. Findings included: Review of resident roster identifies 3 residents (#111, #333, #400) require 2 person assist for transfer with a lift and 4 other residents (#401, #402, #403, #404) with impaired cognition. Interview on 4-5-17 at 12:10 p.m. with licensed nurse B stated the facility had two certified staff on duty from 11:00 p.m. until 6:00 a.m. with one of them being a sleeper in back of facility in the safe room. Observed a twin bed in the safe room.	S5205		

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S5205	Continued From page 3 Interview on 4-5-17 at 12:40 p.m. with owner/operator/RN stated had two certified staff, licensed nurse B and self on duty until 6:00 p.m. then two certified staff on duty until 11:00 p.m. At 11:00 p.m. one certified staff on duty to work the floor and one certified staff on duty as a sleeper in case he/she is needed. - Record review on 4-5-17 at 12:50 p.m. for resident #111 revealed an admit date of 1-13-16 with diagnoses of insulin dependent diabetic, depression, hypertension, osteoarthritis, multiple fractures, and osteoporosis. The Functional Capacity Screen (FCS) dated 6-30-16 recorded resident unable to assist with transfer or walking/mobility, experienced impaired decision making, socially inappropriate behaviors, and falls/unsteadiness. The Negotiated Service Agreement (NSA) dated 6-30-16 recorded resident required two staff assist with sit to stand lift. Resident can propel self when in wheel chair. The Health Care Service Plan (HCSP) dated 6-30-16 recorded two staff assist with use of sit to stand lift for transfers. Resident able to propel self in wheel chair. For transfer needs: Resident to have two person assist with sit to stand lift. Has fracture of right tibia and fibula and is non weight bearing. - On 4-5-17 at 12:05 p.m. observed certified staff C transfer resident #111 from chair using sit to stand lift and transferred resident to toilet. Resident #111 stated he/she fell prior to being	S5205		

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S5205	Continued From page 4	S5205		

admitted to facility and broke two bones in right leg and it is his/her fault the bones had not healed well because he/she did not wear the cast/splint like he/she was supposed to. Resident #111 further stated if he/she having a good day two staff could transfer resident by two person transfer without using lift but he/she preferred the lift to be used. Resident is alert and oriented.

Interview at 12:35 p.m. with licensed nurse B stated resident #111 is a two person assist with sit to stand lift for all transfers.

- Record review for resident #333 revealed admit date of 4-4-17 with diagnoses of post-polio syndrome, Alzheimer ' s muscle weakness, osteoarthritis, anxiety, and hypertension.

FCS dated 4-6-17 recorded resident required physical assistance with transfer and unable to assist with walking/mobility, experienced impaired memory recall and decision making; current or recent problems identified as impaired decision making, impaired hearing, and falls/unsteadiness.

The record lacked a NSA on 4-6-17.

The HCSP dated on 4-4-17 recorded resident a two person assist for transfer using a slide board. The HCSP lacked further documentation.

The record contained a nursing evaluation completed on 4-4-17 at resident's home. Resident dependent for transfer, can't bear weight due to paralysis of bilateral extremities.

On 4-6-17 at 12:15 p.m. observed certified staff D and E transfer resident using a sling hoyer lift

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S5205	Continued From page 5	S5205		

from wheelchair to recliner in commons area. Resident unable to assist with transfer or bear weight. Resident can propel self in wheelchair.

Interview on 4-6-17 at 12:20 p.m. with certified staff D stated, " resident was very (loud), unable to assist with transfer, wanting to stay in room then calls staff to come and get him/her and take to commons area, then wants to go back to room after out in commons area. "

- Record review for resident #222 revealed admit date of 2-17-17 with diagnoses of dementia, Parkinson ' s, anxiety, and high risk of falls.

The record lacked a Functional Capacity Screen (FCS).

The NSA dated 2-17-17 recorded nursing services to be supervised: management of behavioral symptoms. Ambulation/Transfer: Balance sideway and back very poor, ambulate with gait belt with physical assistance.

The HCSP dated 2-17-17 recorded: Transfer needs: one person assist " Always " with gait belt, resident unsteady side to side and falls backwards. Resident gets angry easily, bed and chair alarm on at all times, frequent visual checks when in room unattended. Cognitive at times with frequent hallucinations.

Nurses notes recorded the following:
On 2-19-17, 2-20-17, 2-23-17, 2-25-17 resident up several times during the night shift with hallucinations and behaviors.
3-4-17 at 8:00 a.m. staff reported resident was up and down all night worrying about letting dogs out of house and was very disturbing to another resident keeping him/her awake. Signed licensed

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S5205	Continued From page 6	S5205		

nurse B.
3-11-17at 12:00 noon Staff assisted resident to stand but resident became combative when staff requested he/she hold onto bar to steady self. Resident began yelling, " I am not touching that bar; I don ' t need it because it is nasty and I won ' t touch it. " Resident began swinging hitting staff in the face and attempted to hit second staff member who was able to catch resident ' s wrist. Licensed nurse A arrived and ordered Ativan (for anxiety). Signed licensed nurse B.

On 3-20-17, 3-21-17, 3-22-17, 3-24-17, 3-28-17, 3-30-17, 3-31-17, 4-3-17, 4-4-17, 4-5-17, resident continued to exhibit numerous disruptive behaviors during day and night shifts that required redirection of several staff.

4-6-17 at 2:30 p.m. the owner/operator/RN confirmed had two residents who wandered and required physical assistance due to confusion and three residents who required two staff assist for transfer with sit to stand lift or hoyer lift. The owner/operator/RN stated and confirmed had two certified staff on duty from approximately 6:00 p.m. until 11:00 p.m., then one certified staff on duty from 11:00 p.m. until 6:00 a.m. and one certified staff (sleeper in safe room) from 11:00 p.m. until 6:00 a.m.

Interview on 4-6-17 at 11:10 a.m. with licensed nurse/operator B stated had a fire evacuation on 2-16-17 with two certified staff and self who participated in the evacuation to a safe place. All residents were up for dinner at that time. Another fire evacuation was conducted on 10-16-16 at 6:00 a.m. with two certified staff and self who participated in evacuation to a safe place. All resident up for breakfast at that time. Licensed nurse/operator B stated had not conducted an

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S5205	Continued From page 7 evacuation to a safe place with two staff on duty and residents in rooms instead of all being up in dining room. Interview on 4-10-17 at 11:50 a.m. with owner/operator/RN stated and confirmed had not documented time on evacuations but took approximately six minutes to evacuate. For all residents living in the facility, the owner/operator/RN failed to ensure a sufficient number of staff members take residents who would require assistance in an emergency or disaster to a secure location when only two staff on duty from 6 p.m. to 6 a.m. with 2 residents (#222 and #401) who required constant supervision due to wandering and fall risk and 3 residents (#111, #333, #404) who required two person assist with sit to stand lift or hoyer lift for transfer. This placed all residents in immediate jeopardy. The immediate jeopardy was corrected on 4-7-17 at 6:00 a.m. when owner/operator/RN ensured 3 staff on duty at all times. The written statement dated 4-6-17 at 3:15 p.m. that stated, " I will have three staff on the floor twenty four hours a day seven days a week to cover residents safety. The owner/operator/RN started the twenty four hours seven days a week with 3 staff on duty on 4-7-17 at 6:00 a.m.	S5205		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following:	S5215		

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S5215	Continued From page 8 (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3) The facility identified a census of 8 residents. The sample included 3 residents. Based on record review, interview and observation for all residents, the operator failed to ensure a quarterly review of the home's emergency management plan with employees and residents. Findings included: - Interview on 4-5-17 with licensed nurse B stated had not completed a quarterly review of the emergency management plan with employees and residents since 4-6-16. Review of records revealed no quarterly review of the emergency management plan since 4-6-16. Interview on 4-6-17 at 10:45 a.m. with licensed nurse B and owner/operator/RN stated and confirmed the quarterly review of emergency management plan was not conducted after April 2016.	S5215		

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S5215	Continued From page 9 For all residents, the operator failed to ensure a quarterly review of the home's emergency management plan with employees and residents.	S5215		
S5255 SS=E	26-42-102 (a) Staff Qualifications Sufficent Staff (a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident ' s functional capacity screening, health care service plan, and negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(a) The facility identified a census of 8 residents. The sample included 3 residents and 4 focus reviewed residents. Based on record review, interview, and observation for 1 (#222) of 3 sampled residents and 1 (#401) of 5 non-sampled residents, the owner/operator/Registered Nurse (RN) failed to ensure a sufficient number of qualified staff members to provide each resident with services and care in accordance with the resident ' s functional capacity screen, health care service plan and negotiated service agreement Findings included: - Record review for resident #222 revealed admit date of 2-17-17 with diagnoses of dementia, Parkinson ' s, anxiety, and high risk of falls.	S5255		

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S5255	Continued From page 10 The record lacked a Functional Capacity Screen (FCS). The NSA dated 2-17-17 recorded nursing services to be supervised: management of behavioral symptoms. Toilet resident every two hours and able to let know if needed to go more often. Ambulation/Transfer: Balance sideway and back very poor, ambulate with gait belt with physical assistance. Needs to use call light. The HCSP dated 2-17-17 recorded: Transfer needs: one person assist " Always " with gait belt, resident unsteady side to side and falls backwards. Resident gets angry easily, call nurse for medication, bed and chair alarm on at all times, frequent visual checks when in room unattended. Cognitive at times with frequent hallucinations. Nurses notes recorded the following: On 2-19-17, 2-20-17, 2-23-17, 2-25-17 resident up several times during the night shift with hallucinations and behaviors. 3-3-17 at 1:50 a.m. alarm sounding before certified staff could reach resident he/she was ambulating out of room stating there was an alligator under his/her bed. Signed licensed nurse B. 3-4-17 at 8:00 a.m. staff reported resident was up and down all night worrying about letting dogs out of house and was very disturbing to another resident keeping him/her awake. Signed licensed nurse B. 3-11-17at 12:00 noon Staff assisted resident to stand but resident became combative when staff	S5255		

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S5255	Continued From page 11	S5255		

requested he/she hold onto bar to steady self. Resident began yelling, " I am not touching that bar; I don ' t need it because it is nasty and I won ' t touch it. Resident began swinging hitting staff in the face and attempted to hit second staff member who was able to catch resident ' s wrist. Licensed nurse A arrived and ordered Ativan (for anxiety). Signed licensed nurse B.

3-13-17 at 1:00 p.m. Heard alarm go off, immediately ran towards room, got half way and heard a thump. Entered room to find resident sitting on floor beside bed. Assessed resident and was transferred by two staff to bed. Abrasion noted to back of forearm. Resident going to take a nap. Signed licensed nurse B.

3-13-17 at 7:30 p.m. Resident having behaviors of trying to get up by-self multiple times, calling staff offensive names and hitting staff in face. Resident talked to and calmed down. Signed licensed nurse I.

3-13-17 at 8:00 p.m. Resident continued to need constant reminders not to get up by self. Signed licensed nurse I.

3-17-17 at 8:00 a.m. Night shift reported resident was up to toilet two times during night and attempting to stand unassisted this morning. This nurse reminded resident not to stand without staff assist to prevent falls and also reminded the sound he/she hears is the chair alarm sounding to remind him/her to stay seated. Resident replied, " Well I don ' t care if that alarm sounds, I want to get up. " During the conversation the resident ' s eyes was closed. Resident reclined back in recliner with alarm attached. At 7:30 p.m. Resident spit in staff faces laughing, and slapping at them. Will continue to monitor for behaviors.

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S5255	Continued From page 12 Signed licensed nurse I. 3-20-17 at 9:30 a.m. Resident out in commons area pulling down pants sitting on upholstered recliner thinking it was the toilet. Staff came quickly came and took resident to toilet. Signed licensed nurse J. On 3-20-17, 3-21-17, 3-22-17, 3-24-17, 3-28-17, 3-30-17, 3-31-17, 4-3-17, 4-4-17, 4-5-17, resident continued to exhibit numerous disruptive behaviors during day and night shifts that required redirection of several staff. On 4-6-17 at 2:05 p.m. observed resident #222 ' s alarm going off and he/she got up from wheelchair and walked unsteady gait into another resident ' s room without staff knowledge as no staff available in commons area at this time. Licensed nurse B was on the phone and did not respond to alarm sounding. Surveyor had to ask licensed nurse B to call owner/operator/RN as not enough staff on duty to provide care to residents whose body alarms are going off and no one to respond due to providing care to other residents. On 4-6-17 at 2:20 p.m. observed resident #401 get up out of recliner with body alarm sounding and attempting to follow resident #222 into another resident ' s roon. Body alarm sounding for resident #222 and #401. No response from staff. I interrupted licensed nurse B ' s conversation with a family member to see if resident #222 and #401 supposed to be up ambulating by self since alarms sounding and he/she stated no. Licensed nurse B excused self from conversation and ran to get residents and place back in chairs where alarms sounding. No other staff present at this time in common area.	S5255		

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S5255	Continued From page 13 4-6-17 at 2:30 p.m. the owner/operator/RN arrived and was informed of the above information. The owner/operator/RN stated he/she would provide 3 certified staff on floor duty at all times to ensure residents safety and confirmed had two residents who wandered and required physical assistance due to confusion and three residents who required two staff assist for transfer with sit to stand lift or hoyer lift. For residents #222 and #401, the owner/operator/RN failed to ensure a sufficient number of qualified staff to provide each resident with services and care in accordance with the resident ' s functional capacity screen, health care service plan and negotiated service agreement.	S5255		
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.	S5265		

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S5265	Continued From page 14	S5265		

This REQUIREMENT is not met as evidenced by:
KAR 42-205(a)(1)

The facility identified a census of 8 residents. The sample included 3 residents and 5 non-sampled residents. Based on record review, observation, and interview for 1 (#400) of 5 non-sampled resident, the owner/operator/Registered Nurse (RN) failed to ensure a self-medication assessment completed annually or with a significant change in condition.

Findings included:

- Record review for resident #400 revealed an admit date of 6-1-15 with diagnoses of pain, osteoarthritis, scleroderma, neuropathy, depression, and hip pain.

The functional capacity screen dated 6-29-16 recorded resident required supervision with management of medications.

The negotiated service agreement dated 6-1-16 recorded nursing to manage medications.

The health care service plan dated 6-30-16 recorded see Medication Administration Record (MAR).

The MAR recorded facility Certified Medication Aides (CMA) or licensed nurses administered medication.

The record contained a "self-administration of medication evaluation of resident's ability" form dated 11-16-15. The record lacked further

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S5265	Continued From page 15 "self-administration of medication evaluation of resident's ability" completed forms. The record contained an order dated 11-16-15 for norco 5/325 Milligrams (MG) (for pain) four times a day. The MAR for recorded norco 5/325 MG administered at 3:00 a.m., 9:00 a.m., 3:00 p.m., and 9:00 p.m. Interview on 4-5-17 at 12:10 p.m. with licensed nurse B stated on night shift 11:00 p.m. to 6:00 a.m. two certified nurse aides (CNA) worked. There was not a CMA or licensed nurse on duty at facility from 11:00 p.m. to 6:00 a.m. to administer 3:00 a.m. norco pain medication as scheduled. The CMA on duty would put a norco 5/235 MG pill in a container and place near resident's bed so he/she could take during the night. The CMA would prefill the norco prior to going off duty at 11:00 p.m. and initial as administered at 3:00 a.m. Interview on 4-10-17 at 11:45 a.m. with licensed nurse B stated and confirmed resident #400 self-administered norco 5/325 MG at 3:00 a.m. from a pill container the CMA prefilled. Licensed nurse B also stated and confirmed the last completed self-medication form was 11-16-15. For resident #400, the owner/operator/RN or licensed nurse failed to ensure a self-medication assessment completed annually or with a significant change in condition.	S5265		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications	S5300		

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S5300	Continued From page 16 (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility identifed a census of 8 residents. The sample included 3 residents. Based on record review, interview, and observation for 1 (#222) of 3 resident sampled, the operator/owner/RN failed to ensure all medications administered to resident in accordance with a medical care provider's written order, professional standards of practice, and each manufacturer's recommendations. Findings included: - Record review for resident #222 revealed admit date of 2-17-17 with diagnoses of dementia, Parkinson ' s, anxiety, and high risk of falls. The record lacked a Functional Capacity Screen (FCS).	S5300		

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S5300	Continued From page 17 The NSA dated 2-17-17 lacked documentation that facility to manage medications. The HCSP dated 2-17-17 lacked documentation for who administered medicaions or managed medications. The Medication Administration Record (MAR) dated 3-1-17 through 3-31-17 recorded facility staff administered medications. The MAR dated 4-1-17 through 4-5-17 recorded the facility staff administered medications. Medical care provider at facility on 3-16-17 at 2:00 p.m. wrote order for seroquel 25 Milligrams (MG) orally daily at bedtime (for schizophrenia, bipolar disorder, and major depressive disorder). Nurses notes recorded the following: On 2-19-17, 2-20-17, 2-23-17, 2-25-17 resident up several times during the night shift with hallucinations and behaviors. 3-3-17 at 1:50 a.m. alarm sounding before certified staff could reach resident he/she was ambulating out of room stating there was an alligator under his/her bed. Signed licensed nurse B. 3-4-17 at 8:00 a.m. staff reported resident was up and down all night worrying about letting dogs out of house and was very disturbing to another resident keeping him/her awake. Signed licensed nurse B. 3-11-17at 12:00 noon Staff assisted resident to stand but resident became combative when staff requested he/she hold onto bar to steady self. Resident began yelling, " I am not touching that	S5300		

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S5300	Continued From page 18	S5300		

bar; I don ' t need it because it is nasty and I won ' t touch it. Resident began swinging hitting staff in the face and attempted to hit second staff member who was able to catch resident ' s wrist. Licensed nurse A arrived and ordered Ativan (for anxiety). Signed licensed nurse B.

3-13-17 at 1:00 p.m. Heard alarm go off, immediately ran towards room, got half way and heard a thump. Entered room to find resident sitting on floor beside bed. Assessed resident and was transferred by two staff to bed. Abrasion noted to back of forearm. Resident going to take a nap. Signed licensed nurse B.

3-13-17 at 7:30 p.m. Resident having behaviors of trying to get up by-self multiple times, calling staff offensive names and hitting staff in face. Resident talked to and calmed down. Signed licensed nurse I.

3-13-17 at 8:00 p.m. Resident continued to need constant reminders not to get up by self. Signed licensed nurse I.

3-17-17 at 8:00 a.m. Night shift reported resident was up to toilet two times during night and attempting to stand unassisted this morning. This nurse reminded resident not to stand without staff assist to prevent falls and also reminded the sound he/she hears is the chair alarm sounding to remind him/her to stay seated. Resident replied, " Well I don ' t care if that alarm sounds, I want to get up. " During the conversation the resident ' s eyes was closed. Resident reclined back in recliner with alarm attached. At 7:30 p.m. Resident spit in staff faces laughing, and slapping at them. Will continue to monitor for behaviors. Signed licensed nurse I.

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3-20-17 at 10:00 a.m. Seroquel (medication) not here as pharmacy waiting on prior authorization from physician since insurance wount pay for medication. Signed licensed nurse/operator B.

On 3-20-17, 3-21-17, 3-22-17, 3-24-17, 3-28-17, 3-30-17, 3-31-17, 4-3-17, 4-4-17, 4-5-17, resident continued to exhibit numerous disruptive behaviors during day and night shifts that required redirection of several staff.

On 3-24-17 at 4:00 p.m. Call placed to pharmacy in relation to Seroquel (medication) order and has not received prior authorization. Call placed to medical care provider and was referred to another medical care provider who stated they was checking on this. Signed licensed nurse/operator B.

On 3-28-17 at 10:00 a.m. Call placed to pharmacy to check on authorization for Seroquel (medication) and was denied per pharmacist. Call placed to medical care provider's office and was informed he/she would do something different. Signed licensed nurse/operator B.

On 3-28-17 at 10:25 a.m. called medical care provider and asked what plan is for medication for this resident. Medical care provider would like to try depakote 125 MG daily at 8:00 p.m. Seroquel was discontinued at this time. Staff to update medical care provider in one week to see how resident is doing. Signed licensed nurse/operator B.

On 4-4-17 the nurses notes recorded medical care provider notifed of non-injury fall with no new orders. The record lacked documentation that medical care provider was notifed to inform of how resident was doing with new medication as

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S5300	Continued From page 20 ordered. On 4-6-17 at 2:05 p.m. observed resident #222 ' s alarm going off and he/she got up from wheelchair and walked unsteady gait into room 6 (not resident ' s room) without staff knowledge. On 4-6-17 at 2:20 p.m. observed resident #222 get up out of recliner with body alarm sounding and ambulate to another resident ' s (room 6). Body alarm sounding for resident #222. The resident did not recieve medication Seroquel 25 MG orally daily at bedtime (for schizophrenia, bipolar disorder, and major depressive disorder when ordered on 3-16-17 and the medical care provider was not notified by facility nurse until 3-28-17. On 3-28-17 the seroquel was discontinued and a new order for depakote 125 MG daily at 8:00 p.m. (used for seizures and manic episodes in people with bipolar disorder.) The medical care provider was not notifed a week after medication administered to see how resident was adjusting. For resident #222, the operator/owner/RN failed to ensure all medications administered to resident in accordance with a medical care provider's written order, professional standards of practice, and each manufacturer's recommendations.	S5300		
S5301 SS=D	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;	S5301		

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S5301	Continued From page 21 (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(3)(C)(D) The facility identified a census of 8 residents. The sample included 3 residents and 5 non-sampled residents. Based on record review and interview for 1 (#400) of 5 non-sampled residents, the owner/operator/Registered Nurse (RN) or Certified Medication Aide (CMA) failed to remain with resident until the medication is ingested and failed to document in the Medication Administration Record (MAR) immediately before or following completion of the medication administered. Findings included: - Record review for resident #400 revealed an admit date of 6-1-15 with diagnoses of pain, osteoarthritis, scleroderma, neuropathy, depression, and hip pain. The functional capacity screen dated 6-29-16 recorded resident required supervision with	S5301		

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S5301	Continued From page 22	S5301		

management of medications.

The negotiated service agreement dated 6-1-16 recorded nursing to manage medications.

The health care service plan dated 6-30-16 recorded see Medication Administration Record (MAR).

The MAR recorded facility Certified Medication Aides (CMA) or licensed nurses administered medication.

The record contained an order dated 11-16-15 for norco 5/325 Milligrams (MG) (for pain) four times a day.

The MAR for recorded norco 5/325 MG administered at 3:00 a.m., 9:00 a.m., 3:00 p.m., and 9:00 p.m.

Interview on 4-5-17 at 12:10 p.m. with licensed nurse B stated on night shift 11:00 p.m. to 6:00 a.m. two certified nurse aides (CNA) worked. There was not a CMA or licensed nurse on duty at facility from 11:00 p.m. to 6:00 a.m. to administer 3:00 a.m. norco pain medication as scheduled. The CMA on duty would put a norco 5/235 MG pill in a container and place near resident's bed so he/she could take during the night. The CMA would prefill the norco prior to going off duty at 11:00 p.m. and initial as administered at 3:00 a.m.

Review of the MAR's on 4-5-17 revealed CMA's initial 3:00 a.m. norco 5/325 MG administered at 3:00 a.m.

Interview on 4-10-17 at 11:10 a.m. with licensed nurse B stated and confirmed CMA's prefill norco

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S5301	Continued From page 23 5/325 MG at 11:00 p.m. prior to going off duty for resident to self-administer at 3:00 a.m. due to only had certified nurse aides working the night shift from 11:00 p.m. to 6:00 a.m. For resident #400, the owner/operator/RN or CMA failed to remain with resident until the medication is ingested and failed to document in the MAR immediately before or following completion of the medication administered.	S5301		