STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087183	A. BUILDING: _____ B. WING _____	04/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHENEY GOLDEN AGE HOME PLUS	802 NORTH MAIN STREET CHENEY, KS 67025

(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 Resurvey at the above named Home Plus Facility in Cheney, Kansas on 4/12/17, 4/13/17, 4/17/17, and 4/19/17.	S 000		
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. This REQUIREMENT is not met as evidenced by:	S5028		

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

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S5028	Continued From page 1 KAR 26-42-101(f)(3)(C) The census equalled seven the sample included three Residents. Based on observations, interviews and reviews of record, for one of three sampled Residents with bruising and unwitnessed falls (#187); for two of three sampled with unwitnessed falls when identified with need for physical assistance (#189 and #185; the Operator failed to ensure the incidents thoroughly investigated to rule out potential neglect, report as required, and failed to maintain a written record of thorough investigations. Findings included: - Review of record revealed #187 admitted to facility 11/01/16 with diagnoses of Progressive supranuclear opthalmoplegia, Hypertension, Hypothyroidism, Diabetes, Hyperlipidemia, and Major depressive disorder. Current functional capacity screen (FCS) of 11/01/16 assessed #187 in need of physical assistance with bathing, toileting, transfers, and mobility; in need of supervision with dressing; independent with eating; unable to perform medication and treatment management; with decision making impairment, falls/unsteadiness, impaired vision, used walker and wheelchair; usually understood and understands for communication. Negotiated Service Agreement (NSA) and Health Service Plans (HSP) of 11/01/16 recorded physical assistance to be provided by staff with bathing, toileting, transfers, and mobility. The NSA lacked services related to fall prevention. The HSP identified #187 as a risk, but lacked individualized interventions to address this	S5028		

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S5028	Continued From page 2 identified need. By observation on 4/13/17 at 10:43am, in #187's room, observed #187 in recliner... alert, watching TV, managing remote control independently... stated he/she did not leave room for meals... sometimes went out to eat with family, or just to spend time with family... otherwise rarely left room or communicated with others. Nurses' Notes documentation of falls: 3/03/17 - 1630 - Resident found on floor by staff in restroom... active range of motion to upper and lower extremities...oriented to person and place... denies hitting head, no injuries found The record lacked evidence of staff physical assistance at the time of fall in restroom as recorded in the NSA/HSP. The record lacked evidence of a thorough investigation to rule out neglect. 12/06/16 - 1830 - Resident complained of pain to the right rib area when coughing, deep breathing and with movement... has small purple bruise to the right upper trunk distal to the axilla... Resident reports that he/she had fallen in the bathroom when transferring on Sunday... The record lacked evidence of staff physical assistance at the time of fall in restroom as recorded in the NSA/HSP. The record lacked evidence of a thorough investigation to rule out neglect. On 4/13/17 at 2:42pm Operator/LPN #F stated at previous facility they stated #187 would constantly get up without assistance... has dramatically decreased since moving here... have Fall Incident Reports/Investigations...	S5028		

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S5028	Continued From page 3 Operator/LPN #F provided Fall Incident Report/Investigation for an incident on 11/10/16 when Resident fell attempting to pick up a dropped donut. No investigations provided for the 12/06/16 bruising with alleged fall, or the 3/03/17 discovery on floor. The Operator failed to ensure the incidents of #187 treated as a potential allegation of neglect due to absence of staff physical assistance as recorded in the NSA/HSP; failed to thoroughly investigate the incidents to rule out neglect, failed to report as required, and failed to maintain documentation of each thorough investigation to rule out neglect. - Review of record revealed #189 admitted to facility 4/14/16 with diagnoses of Major depressive disorder, Anxiety, Insomnia, Macular degeneration, Glaucoma, Hypertension, Muscle weakness, Osteoporosis, and Arteriosclerotic heart disease. Current functional capacity screen (FCS) of 4/14/16 assessed #189 unable to perform medication and treatment management; in need of physical assistance with bathing, dressing, toileting, transfers, mobility and eating; with bladder incontinence, impaired memory recall, falls/unsteadiness, impaired vision and hearing; used a walker and a wheelchair. NSA of 4/14/16 recorded physical assistance provided by staff with bathing, dressing, toileting, transfers, and mobility. The NSA lacked individualized interventions to serve as a fall prevention plan for Resident, due to FCS identifying falls/unsteadiness.	S5028		

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S5028	Continued From page 4 Home Plus Service Plan of 4/14/16 - documented "fall risk, unsteady gait, 2 person assist with transfers" Health Care Plan/Nursing Plan of 4/14/16 - documented "1-2 person staff assist with toileting... wheelchair for transfers, staff to propel... 2 person staff assist with all transfers... encourage to keep call light necklace on at all times... C.N.A. Care Plan documented "requires transfer assist of 1 (circled) 2 (circled)... "Fall risk" with "X" beside it but not further interventions or directions. By observation on 4/13/17 at 11:30am, Direct Care Staff #H applied a Velcro strapped gait belt, cued #189 to put feet back, scoot forward, stand with staff assistance... #H held onto gait belt as #189 ambulated to bathroom and then to dining room table. Nurses' Notes documentation of falls: 01/15/17 - 1745 - Resident let go of walker and sat on floor then laid down... did not hit head, no injuries, deformities, or abnormal rotations of the extremities...denies pain/discomfort... The record lacked evidence of staff physical assistance at the time of fall while ambulating, as recorded in the NSA/HSP. The record lacked evidence of a thorough investigation to rule out neglect. 7/30/16 - 0550 - got out of bed by self, fell going to bathroom, fell landing on buttocks... third shift med aide found him/her immediately sitting on floor... stated was fine... no bruising, swelling, lacerations... assisted up to bathroom...	S5028		

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S5028	Continued From page 5 The record lacked evidence of staff physical assistance at the time of fall on way to restroom as recorded in the NSA/HSP. The record lacked evidence of a thorough investigation to rule out neglect. 5/25/16 - 0020 - Resident used pendant to notify staff he/she was on the floor... stated slipped out of bed when getting into wheelchair... no injuries, denies pain, denied hitting head... The record lacked evidence of staff physical assistance at the time transfer into wheelchair as recorded in the NSA/HSP. The record lacked evidence of a thorough investigation to rule out neglect. On 4/13/17 at 1:05pm Operator/LPN (licensed practical nurse) #F stated fall plan is pretty much wait for assistance, call for help, and sensor on bed... #F stated we have Incident Reports/investigations... Operator/LPN #F provided the Fall Incident Report/Investigations for 01/15/17, and 7/30/16, no report for 5/25/16. These reports failed to demonstrate a thorough investigation completed to rule out neglect. The Operator failed to ensure the incidents of #189 treated as a potential allegation of neglect due to absence of staff physical assistance as recorded in the NSA/HSP; failed to thoroughly investigate the incidents to rule out neglect, failed to report as required, and failed to maintain documentation of each thorough investigation to rule out neglect. - Review of record revealed #185 admitted to	S5028		

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S5028	Continued From page 6 facility 11/16/16 with diagnoses of Diabetes, Dementia, Parkinson's, Chronic pain, Hypertension, Chronic embolism and thrombosis, Dementia, Osteoarthritis, General weakness, Hypercholestolemia, Anemia, Hypothyroid, and Gastroesophageal reflux disease. Current functional capacity screen (FCS) of 11/16/16 assessed #185 in need of physical assistance with bathing, dressing, toileting, transfers, and mobility; independent with eating; unable to perform medication and treatment management; with incontinence, short term memory, long term memory, memory recall, and decision making impairments; falls/unsteadiness, impaired vision, used walker and wheelchair; understood and understands for communication. NSA of 11/16/16 recorded physical assistance with bathing, dressing, toileting, transfers, mobility; medication management by facility. The NSA lacked individualized interventions to serve as a fall prevention plan for Resident. Home Plus Service Plan of 11/16/16 - unsteady, assist of one with ambulation and four wheel walker... history of falls Health Care Plan/Nursing Plan of 11/16/16 - documented Assist with ambulation to meals, encourage to keep call light on at all times C.N.A. Care Plan documented "walks with assist, with walker, gait unsteady, requires transfer assist, "Fall risk" with "X" beside it but not further interventions or directions. By observation on 4/13/17 at 10:20am, #185 in recliner in room, leaning slightly to the right in the chair... watching TV and adjusting channel and	S5028		

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S5028	Continued From page 7 sound independently. By observation on 4/13/17 at 11:38am, Direct Care Staff #H assisted #185 up out of chair and walked with him/her to table as #185 used a walker. Nurses' Notes documentation of falls: 02/16/17 - Certified Medication aide reported that Resident found lying on the floor in room... stated he/she was side ways... active range of motion of bilateral upper and lower extremities... denied hitting head or feeling dizzy... no injuries... The record lacked evidence of staff physical assistance at the time of fall while ambulating as recorded in the NSA/HSP. The record lacked evidence of a thorough investigation to rule out neglect. On 4/13/17 at 1:46pm Operator/LPN (licensed practical nurse) #F provided a Fall Investigation report... by review this report failed to document a thorough investigation to rule out neglect. The Operator failed to ensure the incidents of #185 treated as a potential allegation of neglect due to absence of staff physical assistance as recorded in the NSA/HSP; failed to thoroughly investigate the incidents to rule out neglect, failed to report as required, and failed to maintain documentation of each thorough investigation to rule out neglect.	S5028		
S5105 SS=E	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,	S5105		

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S5105	Continued From page 8 based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The census equalled seven the sample included three Residents. Based on observations, interviews, and reviews of records, for three of three sampled (#189, #187, and #185), the Operator failed to ensure the Negotiated Service Agreement (NSA) contained a description of the services the Resident to receive, identification of the provider of each service, and the payment source if service by and outside provider. Findings included: - Review of record revealed #189 admitted to facility 4/14/16 with diagnoses of Major depressive disorder, Anxiety, Insomnia, Macular degeneration, Glaucoma, Hypertension, Muscle weakness, Osteoporosis, and Arteriosclerotic heart disease. Current functional capacity screen (FCS) of	S5105		

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S5105	Continued From page 9 4/14/16 assessed #189 unable to perform medication and treatment management; in need of physical assistance with bathing, dressing, toileting, transfers, mobility and eating; with bladder incontinence, impaired memory recall, falls/unsteadiness, impaired vision and hearing; used a walker and a wheelchair. Negotiated Service Agreement (NSA) of 4/14/16 recorded physical assistance with bathing, dressing, toileting, transfers, and mobility. The NSA lacked services of physical assistance with eating or services for treatment management. By observation on 4/13/17 at 11:30am, Direct Care Staff #H applied a Velcro strapped gait belt, cued #189 to put feet back, scoot forward, stand with staff assistance... #H held onto gait belt as #189 ambulated to bathroom and then to dining room table. Medical record documented #189 began PT (physical therapy) on 4/18/16, again on 5/02/16, and again on 3/01/17. The NSA lacked the service of PT added (or discontinued), and lacked the name of the provider and payment source for each episode of PT. Medical record Nurses' Notes documented thirty entries of assessment, treatments, and stages of healing of pressure areas to heels of feet. The NSA/HSP (health service plan) lacked a description of services provided to treat the pressure areas to heels. On 4/13/17 at 1:05pm, Operator/LPN (licensed practical nurse) #F confirmed outside provider information and heel treatments not added to the NSA as required... stated I am not good at going back to NSA and adding items later.	S5105		

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S5105	Continued From page 10 The Operator failed to ensure the NSA contained a description of the services #189 to receive, in regard to treatment management and physical assistance with eating; and failed to ensure the NSA contained the name of the outside provider for PT and the payment source. - Review of record revealed #187 admitted to facility 11/01/16 with diagnoses of Progressive supranuclear opthalmoplegia, Hypertension, Hypothyroidism, Diabetes, Hyperlipidemia, and Major depressive disorder. Current functional capacity screen (FCS) of 11/01/16 assessed #187 in need of physical assistance with bathing, toileting, transfers, and mobility; in need of supervision with dressing; independent with eating; unable to perform medication and treatment management; with decision making impairment, falls/unsteadiness, impaired vision, used walker and wheelchair; usually understood and understands for communication. NSA of 11/01/16 recorded physical assistance with bathing, toileting, transfers, and mobility; medication management by facility. The NSA lacked services related to treatment management, and failed to identify what type of diet this Resident to receive (Resident an insulin dependent diabetic). On 4/13/17 at 2:17pm Operator/LPN #F stated the physician left the diet order request blank at time of admission... we usually do a Regular diet if nothing specified... confirmed "treatment management" not on the NSA tool. The Operator failed to ensure the NSA contained	S5105		

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S5105	Continued From page 11 a description of the services #187 to receive, in regard to treatment management and diet order. - Review of record revealed #185 admitted to facility 11/16/16 with diagnoses of diabetes, Dementia, Parkinson's, Chronic pain, Hypertension, Chronic embolism and thrombosis, Dementia, Osteoarthritis, General weakness, Hypercholestolemia, Anemia, Hypothyroid, and Gastroesophageal reflux disease. Current functional capacity screen (FCS) of 11/16/16 assessed #185 in need of physical assistance with bathing, dressing, toileting, transfers, and mobility; independent with eating; unable to perform medication and treatment management; with incontinence, short term memory, long term memory, memory recall, and decision making impairments; falls/unsteadiness, impaired vision, used walker and wheelchair; understood and understands for communication. NSA of 11/16/16 recorded physical assistance with bathing, dressing, toileting, transfers, mobility; medication management by facility. The NSA lacked services related to treatment management. By observation on 4/13/17 at 11:38am, Direct Care Staff #H assisted #185 up out of chair and walked with him/her to table as #185 used a walker. Medical record documented an order obtained on 4/11/17 for OT (occupational therapy) evaluation and treatment, due to general weakness, decreased hand grasp, and poor trunk control. The NSA lacked the addition of this service, or the name of the provider, or the payment source.	S5105		

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S5105	Continued From page 12 On 4/13/17 at 1:46pm, Operator/LPN (licensed practical nurse) #F stated they came and did a screen, then I got the order from Dr... they have the order... waiting for them to come and evaluate and treat... may be next week... I probably haven't got it added to the NSA... #185 knows about it... lot of the time family just goes with what he/she wants... #185 began PT (physical therapy) on 4/18/16, again on 5/02/16, and again on 3/01/17. The NSA lacked the service of PT added (or discontinued), and lacked the name of the provider and payment source for each episode of PT. The Operator failed to ensure the NSA contained a description of the services #185 to receive, in regard to treatment management and OT.	S5105		
S5155 SS=F	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)	S5155		

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S5155	Continued From page 13 The census equalled seven the sample included three Residents. Based on observations, interviews, and reviews of record, for three of three sampled (#187, #189, and #185), 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, in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Review of record revealed #187 admitted to facility 11/01/16 with diagnoses of Progressive supranuclear opthalmoplegia, Hypertension, Hypothyroidism, Diabetes, Hyperlipidemia, and Major depressive disorder. Current functional capacity screen (FCS) of 11/01/16 assessed #187 in need of physical assistance (2) with bathing, toileting, transfers, and mobility; in need of supervision (1) with dressing; independent (0) with eating; unable to perform (3) medication and treatment management; with decision making impairment, falls/unsteadiness, impaired vision, used walker and wheelchair; usually understood and understands for communication. The medical record contained an 11/02/16 physician's order for Blood sugar accuchecks three times weekly fasting. If signs/symptoms of hypo/hyperglycemia or if blood sugar < 80 call MD (physician). The medical record contained a 4/11/17 physician's for Blood sugar accuchecks three times weekly fasting. If signs/symptoms of hypo/hyperglycemia or if blood sugar < 70 call MD (physician).	S5155		

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	B087183	A. BUILDING: _____ B. WING _____	04/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHENEY GOLDEN AGE HOME PLUS	802 NORTH MAIN STREET CHENEY, KS 67025

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S5155	Continued From page 14 The medical record contained a physician's order for Levemir insulin at bedtime for diabetes (Resident will self inject). Nurses' Notes documentation of falls: 3/03/17 - 1630 - Resident found on floor by staff in restroom... active range of motion to upper and lower extremities...oriented to person and place... denies hitting head, no injuries found 12/06/16 - 1830 - Resident complained of pain to the right rib area when coughing, deep breathing and with movement... has small purple bruise to the right upper trunk distal to the axilla... Resident reports that he/she had fallen in the bathroom when transferring on Sunday... 11/10/16 - 0830 - Resident had fall in room... Resident eating breakfast and states dropped donut tried to pick it up... found on right side of recliner sitting right leg extended out left leg bent at knee... range of motion within normal limits... states hit head on bedside table... NSA of 11/01/16 recorded physical assistance with bathing, toileting, transfers, and mobility; medication management by facility. The NSA lacked services related to fall prevention, glucometer testing, and insulin preparation/injections. On 4/13/17 at 2:42pm Operator/LPN #F stated we do the glucometer (blood sugar) testing... we do it fasting three times a week but it's not on the NSA/HSP... we do all the insulin pen prep... put on needle, prime, dial the dose... Resident self injects... that's not on the NSA/HSP... in regard to a fall plan... using the call light pendant... tell him/her to call for assistance... no other individualized interventions on the NSA/HSP... did not add any interventions after the falls...	S5155		

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S5155	Continued From page 15 The Operator failed to ensure a Licensed nurse provided or coordinated the provision of necessary health care services that met the needs of #187, in regard to fall prevention, blood sugar testing, and insulin pen preparation for self injection. - Review of record revealed #189 admitted to facility 4/14/16 with diagnoses of Major depressive disorder, Anxiety, Insomnia, Macular degeneration, Glaucoma, Hypertension, Muscle weakness, Osteoporosis, and Arteriosclerotic heart disease. Current functional capacity screen (FCS) of 4/14/16 assessed #189 unable to perform (3) medication and treatment management; in need of physical assistance (2) with bathing, dressing, toileting, transfers, mobility and eating; with bladder incontinence, impaired memory recall, falls/unsteadiness, impaired vision and hearing; used a walker and a wheelchair. NSA of 4/14/16 recorded physical assistance with bathing, dressing, toileting, transfers, and mobility. The NSA lacked services of physical assistance with eating or services for treatment management. The NSA lacked individualized interventions to serve as a fall prevention plan for Resident, due to FCS identifying falls/unsteadiness. Nurses' Notes documentation of falls: 01/15/17 - 1745 - Resident let go of walker and sat on floor then laid down... did not hit head, no injuries, deformities, or abnormal rotations of the extremities...denies pain/discomfort... 12/19/16 - 0030 - rolled out of bed... skin tear to left exterior arm... abrasion to side of left eye...	S5155		

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S5155	Continued From page 16	S5155		

range of motion within normal limits... neuro intact...
8/28/16 - 0200 - rolled out of bed trying to straighten covers... denies pain, active range of motion... assisted to bed by Certified Medication aide and positioned in middle of bed...
7/30/16 - 0550 - got out of bed by self, fell going to bathroom, fell landing on buttocks... third shift med aide found him/her immediately sitting on floor... stated was fine... no bruising, swelling, lacerations... assisted up to bathroom...
5/25/16 - 0020 - Resident used pendant to notify staff he/she was on the floor... stated slipped out of bed when getting into wheelchair... no injuries, denies pain, denied hitting head...

Home Plus Service Plan of 4/14/16 - documented "fall risk, unsteady gait, 2 person assist with transfers"

Health Care Plan/Nursing Plan of 4/14/16 - documented "1-2 person staff assist with toileting... wheelchair for transfers, staff to propel... 2 person staff assist with all transfers... encourage to keep call light necklace on at all times...

C.N.A. Care Plan documented "requires transfer assist of 1 (circled) 2 (circled)... "Fall risk" with "X" beside it but not further interventions or directions

On 4/13/17 at 1:05pm Operator/LPN (licensed practical nurse) #F stated fall plan is pretty much wait for assistance, call for help, and sensor on bed... #F confirmed sensor pad alarm and other individualized interventions not addressed on the NSA/HSP (health service plan)... added the sensor pad probably after one of the falls... do not know the date... two person transfer was at time of admission because of sling on arm, hasn't

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S5155	Continued From page 17 been two person transfer for long time... have not changed NSA/HSP since admission to reflect bed sensor, one person transfer, new falls with new interventions to address them... The Operator failed to ensure a Licensed nurse provided or coordinated the provision of necessary health care services that met the needs of #189, in regard to fall prevention, transfers and ambulation techniques, and use of gait belt. - Review of record revealed #185 admitted to facility 11/16/16 with diagnoses of Diabetes, Dementia, Parkinson's, Chronic pain, Hypertension, Chronic embolism and thrombosis, Dementia, Osteoarthritis, General weakness, Hypercholestolemia, Anemia, Hypothyroid, and Gastroesophageal reflux disease. Current functional capacity screen (FCS) of 11/16/16 assessed #185 in need of physical assistance (2) with bathing, dressing, toileting, transfers, and mobility; independent (0) with eating; unable to perform (3) medication and treatment management; with incontinence, short term memory, long term memory, memory recall, and decision making impairments; falls/unsteadiness, impaired vision, used walker and wheelchair; understood and understands for communication. NSA of 11/16/16 recorded physical assistance with bathing, dressing, toileting, transfers, mobility; medication management by facility. The NSA lacked services related to treatment management. The NSA lacked individualized interventions to serve as a fall prevention plan for Resident, due	S5155		

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S5155	Continued From page 18 to FCS identifying falls/unsteadiness. Nurses' Notes documentation of falls: 11/16/16 - 1250 - admitted from another facility...assisted to facility in wheelchair... is one person assist... has bruising to arm and lower back from previous fall at another facility... 02/16/17 - Certified Medication aide reported that Resident found lying on the floor in room... stated he/she was side ways... active range of motion of bilateral upper and lower extremities... denied hitting head or feeling dizzy... no injuries... Home Plus Service Plan of 11/16/16 - unsteady, assist of one with ambulation and four wheel walker... history of falls Health Care Plan/Nursing Plan of 11/16/16 - documented Assist with ambulation to meals, encourage to keep call light on at all times C.N.A. Care Plan documented "walks with assist, with walker, gait unsteady, requires transfer assist, "Fall risk" with "X" beside it but not further interventions or directions On 4/13/17 at 1:46pm Operator/LPN (licensed practical nurse) #F stated fall plan for #185 is just remind to continue to use call light and wait for assistance... confirmed NSA/HSP lacked individualized interventions to prevent falls identified on the admission FCS as a risk... The Operator failed to ensure a Licensed nurse provided or coordinated the provision of necessary health care services that met the needs of #185, in regard to fall prevention.	S5155		

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S5300	Continued From page 19	S5300		
S5300 SS=D	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 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 census equalled seven the sample included three Residents. The Resident roster identified six Residents as receiving medication management, three included in the sample. Based on record reviews and interviews, for one of three sampled (#185), the Operator failed to ensure all medications and biologicals administered to Residents in accordance with written medical care provider order, and in accordance with professional standards of practice. Findings included:	S5300		

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S5300	Continued From page 20 - Review of record revealed #185 admitted to facility 11/16/16 with diagnoses of diabetes, Dementia, Parkinson's, Chronic pain, Hypertension, Chronic embolism and thrombosis, Dementia, Osteoarthritis, General weakness, Hypercholestolemia, Anemia, Hypothyroid, and Gastroesophageal reflux disease. Current functional capacity screen (FCS) of 11/16/16 assessed #185 unable to perform medication and treatment management. NSA of 11/16/16 recorded medication management by facility. The NSA lacked services related to treatment management. The medical record contained an 11/16/16 admission physician's order: "Clotrimazole-betamethasone cream apply to feet at HS (bedtime)." The December POS (physician order sheet) signed by physician printed the clotrimazole as a "PRN" (as needed) order: "apply a thin film to bilateral feet every evening at bedtime as needed for rash." The medical record lacked an order changing this treatment from daily to PRN. Review of the MAR's (medication adminstration records) from 11/16/16 to 4/12/17 documented administration of this treatment every day. The record lacked docuemntation of an onging rash issue with #185's feet, and lacked consult with the physician after four weeks of treatement as suggested by the section titled "How to Use clotrimazole" on www.webmd.com. By interview on 4/13/17 at 1:57pm the	S5300		

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S5300	Continued From page 21 Operator/LPN (licensed practical nurse) #F stated I don't have a physician's order to change the treatment from daily to PRN... I send the top copy of the POS to the physician monthly to sign... confirmed the PRN order with physician's signature since 12/2016... I think they just missed it was PRN all this time and continued to administer the cream... Operator/LPN #F stated I am the one who reviews them when back from physician in preparation for each new month... The Operator failed to ensure all medications and biologicals administered to #185 in accordance with written medical care provider orders and in accordance with professional standards of practice.	S5300		
S5327 SS=E	26-42-205 (l) (2) Medication Regimen Review Variance Report (l) (2) The licensed pharmacist or licensed nurse shall notify the medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist shall notify a licensed nurse within 48 hours of any variance identified in the resident ' s regimen review that does not require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident ' s medical care provider. The licensed nurse shall seek a response from the medical care provider within five working days of the medical care provider ' s notification of a variance. This REQUIREMENT is not met as evidenced by:	S5327		

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S5327	Continued From page 22 KAR 26-42-205(l)(2) The census equalled seven the sample included three Residents. The Resident Roster identified six of seven Residents as receiving medication management. Based on interview and review of record for one of three sampled with facility managed medications (#189), the licensed nurse failed to seek a response from the medical care provider within five working days of the medical care provider's notification of a variance. Findings included: - Review of record revealed #189 admitted to facility 4/14/16 with diagnoses of Major depressive disorder, Anxiety, Insomnia, Macular degeneration, Glaucoma, Hypertension, Muscle weakness, Osteoporosis, and Arteriosclerotic heart disease. Current functional capacity screen (FCS) of 4/14/16 assessed #189 unable to perform medication management; in need of physical assistance with bathing, dressing, toileting, transfers, and mobility; with bladder incontinence, impaired memory recall, falls/unsteadiness, impaired vision and hearing; used a walker and a wheelchair. Negotiated service agreement (NSA) of 4/14/16 recorded medications managed by facility. Medical record contained a drug regimen review page with reviews documented on the following dates: 7/06/16 - note to physician - this variance report inquired if physician would 1) decrease Mirtazapine to 30mg daily, and 2) trial	S5327		

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S5327	Continued From page 23	S5327		

discontinuation of aripiprazole, and requested a risk versus benefit statement to continue the medications unchanged.
10/06/16 - note to physician - this variance report inquired if physician would order lab tests for atorvastatin, potassium, and furosemide
01/19/17 - note to physician - this variance report inquired about the continuing need for daily meclizine (medication for dizziness), and requested a risk versus benefit statement to continue the medication.

The medical record lacked these variance reports.

By interview on 4/13/17 at 11:07am, Operator/LPN (licensed practical nurse) #F stated the pharmacist gives the reports to me... I mail them to the Dr... I don't have them... Dr. never sent them back... must have sent them on to the pharmacy because I talked with pharmacy about the order... Operator/LPN #F searched the medical record and overflow record, unable to locate the variance reports.

Operator/LPN #F contacted the pharmacist. Pharmacist faxed three reports to Operator/LPN #F. These reports each dated "4/13/17" and lacked the date of completion by pharmacist. These reports lacked evidence of physician response to the variance or note by pharmacist.

The licensed nurse failed to seek a response from the medical care provider for #189, within five working days of the medical care provider's notification of a variance.