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	B006004	A. BUILDING: _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	1126 S HORTON FORT SCOTT, KS 66701

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named home plus facility conducted on 4-10-17, 4-11-17, 4-12-17, and 4-13-17.	S 000		
S5165 SS=D	26-42-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(e) The facility reported a census of 9 residents. The sample included 3 residents. Based on record review and interview for 1 (#411) of 1 sampled resident requiring blood glucose monitoring, a nursing procedure not included in the medication aide curriculum, the operator failed to ensure the licensed nurse delegated the procedure to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included: - Record review for resident #411 revealed admission on 7-7-16 with diagnoses Type 2 Diabetes Mellitus, Vitamin D Deficiency, Debility, Hyperlipidemia, Over Active Bladder, Insomnia and Hypertension. The Functional Capacity (FCS) screen dated	S5165		

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

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S5165	Continued From page 1	S5165		

7-7-16 recorded resident independent with management of medications and treatments. The FCS failed to accurately reflect the resident's status in regard to medication and treatment management.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 7-7-16 stated: Medications: Self, CMA (Certified Medication Aide), RN (Registered Nurse). The NSA/HCSP lacked documentation for delegated certified medication aides to perform blood glucose monitoring as ordered by physician.

Physician's Order dated 1-25-17 stated: "May test up to 6-7 times daily as needed for low blood sugar"

Interview on 4-11-17 at 12:47 pm with Certified Staff B stated he/she performed blood sugar monitoring for Resident #411 four times a day. Certified Staff B confirmed he/she had worked at the facility for 1 ½ years and during that time had not been checked for competency prior to performing blood glucose monitoring.

Interview on 4-11-17 at 4:25 pm with Operator and Licensed Staff A stated resident #411 is the only resident currently receiving blood glucose monitoring. Operator presented for review a spiral notebook kept in Resident #411's room with documentation of blood sugar monitoring results performed four times a day (before meals and at bedtime: 8 am, 12 pm, 5 pm and 8 pm). Operator confirmed the record lacked documentation of staff performing the test and stated all blood sugar monitoring was done by Certified Medication Aides. Operator and Licensed Staff A confirmed the licensed nurse failed to appropriately delegate performance of

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S5165	Continued From page 2 blood glucose monitoring to certified medication aides. The operator failed to ensure the licensed nurse delegated blood sugar monitoring with a glucometer to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S5165		
S5185 SS=D	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(c) The facility reported a census of 9 residents. The sample included 3 residents. Based on record review and interview for 1 (#411) of 3 sampled residents with an order for a therapeutic diet, the operator failed to ensure the diet shall be prepared according to instructions from a medical	S5185		

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S5185	Continued From page 3	S5185		

care provider or license dietitian.

Findings included:

- Record review for resident #411 revealed admission on 7-7-16 with diagnoses Type 2 Diabetes Mellitus, Vitamin D Deficiency, Debility, Hyperlipidemia, Over Active Bladder, Insomnia and Hypertension.

The Functional Capacity Screen (FCS) dated 7-7-16 recorded resident required physical assistance with bathing; independent with dressing, toileting, transfers, walking/mobility, eating and management of medications/treatments. (Note: The FCS failed to accurately reflect the resident's status in regard to activities of daily living.) Occasionally incontinent of bladder. No problems with cognition. Current problems/risks identified included falls, impaired hearing and impaired vision. Resident uses walker and wheelchair.

The Negotiated Service Agreement (NSA) dated 7-7-16 stated:
Diet: Regular Low Concentrated Sweets.

Admission orders provided by Operator and dated 7-7-16: Regular Diet Low Sugar and Salt.

Resident Plan of Care Summaries dated 12-29-16 and 4-4-17 recorded resident on "Diabetic" Diet: Regular Low Concentrated Sweets.

Interview on 4-10-17 at 5:15 pm with Operator confirmed the facility lacked written instructions for resident's therapeutic "Low Concentrated Sweets" diet. Further confirmed the diet had not been clarified with the resident's physician.

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S5185	Continued From page 4 Interview on 4-11-17 at 12:17 pm with dietary staff C confirmed the facility lacked written instructions for therapeutic diets. Stated he/she prepares meals by following the menus some of which were signed by a dietitian. Further stated he/she prepares alternatives as requested by the residents. For resident #411, the operator failed to ensure the provision or coordination of dietary services to the resident as identified in the resident's negotiated service agreement for a low concentrated sweets diet.	S5185		
S5251 SS=E	26-42-105 (f) (11) Resident Records 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 26-42-105(f)(11) The facility reported a census of 9 residents. The sample included 3 residents. Based on record review and interview for 2 (#410, #411) of 3 sampled residents, the operator failed to ensure documentation of all incidents, symptoms, and other indications of illness or injury including date, time of occurrence, actions taken and results of the actions. Findings included:	S5251		

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S5251	Continued From page 5 - Record review for Resident #410 revealed admission on 4-15-16 with diagnoses Dementia with Lewy Bodies and Auditory Hallucinations, Hyperlipidemia, Depression, Edema, Muscle Weakness, Poly-Osteoarthritis and History of Falls. The Functional Capacity Screen (FCS) dated 4-6-17 recorded resident unable to perform bathing, dressing and management of medications/treatments; required physical assistance with toileting; supervision of walking/mobility and independent with transfers and eating. Continent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks identified included falls, impaired hearing, impaired decision-making and wandering. The Negotiated Service Agreement (NSA) dated 4-6-17 recorded services as follows: Bathing: supervision needed 1 assist at times twice weekly. Dressing: Self - supervision - assist at times. Hearing aides: yes Toileting: Self assist at times. Transferring: self Mobility: Self - walker at times. Medications: CMA (Certified Medication Aide), RN (Registered Nurse). Wound Care Treatment Note for wound care at an outpatient provider stated the following: 2-27-17: Diagnosis: Pressure ulcer of heel; localized edema; Stage III pressure ulcer of right heel; Late onset Alzheimer's disease with behavioral disturbance. Treatment Diagnosis: Resolving stage 3	S5251		

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pressure ulcer right heel. Wound site covered with clear callus, no drainage on dressing. Bilateral lower legs clear and free of edema. Medial gluteal folds dry but no open areas of drainage. (Physician) to examine. Callus removed from wound site, no ulcer underneath ...discharged from outpatient wound care and home health. Staff will apply protective white foam dressing over callus site until new shoes and insoles come in ...Demonstrated to (family member) application of white foam to callus site, if wet, soiled, etc. to use as protective dressing until shoes and insoles are available.

Record review of Nurse's Notes stated:
9-21-16 (no time indicated): "...Instructed staff to keep feet elevated. Silvadene cream applied to affected areas. Resident is not cooperating but continue to instruct staff to elevate bilateral lower extremities because of increased edema." Signed by Licensed Staff B.

9-29-16 (no time indicated): "Antibiotic therapy for sore on heel completed. Affected area resolving, reddened areas fading." Signed by Licensed Staff B.

10-13-16 at 8:00 pm: "Resident has order for intravenous antibiotic therapy for 14 days for heel infection. PICC line on right arm noted, to be given IV antibiotic therapy by home health agency." Signed by Licensed Staff B.

11-11-16 (no time indicated): "Received new order for oral antibiotic therapy for wound on right foot to start once medication available." Signed by Licensed Staff B.

Note: The record lacked further documentation from 11-18-16 until 1-3-17.

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S5251	Continued From page 7 1-3-17: "As of today wound care should be twice a month. (Home Health Agency) to change dressing three times a week." Signed by Licensed Staff B. The record lacked documentation of wound appearance, signs/symptoms of infection, placement of PICC line, and healing of wound. Interview on 4-11-17 at 10:28 am and at 5:00 pm with Licensed Staff B confirmed resident had an open area to right heel which became infected and was treated as indicated in the nurses notes. Confirmed he/she failed to document ongoing assessments of resident's wound including date when first noticed, effectiveness of treatments, symptoms of infection and when the wound was healed. For Resident #410, the operator failed to ensure documentation of ongoing assessments of resident's wound, signs/symptoms of infection and effectiveness of treatments. - Record review for resident #411 revealed admission on 7-7-16 with diagnoses Type 2 Diabetes Mellitus, Vitamin D Deficiency, Debility, Hyperlipidemia, Over Active Bladder, Insomnia and Hypertension. The Functional Capacity Screen (FCS) dated 7-7-16 recorded resident required physical assistance with bathing; independent with dressing, toileting, transfers, walking/mobility, eating and management of medications/treatments. (Note: The FCS failed to accurately reflect the resident's status in regard to activities of daily living.) Occasionally incontinent	S5251		

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S5251	Continued From page 8	S5251		

of bladder. No problems with cognition. Current problems/risks identified included falls, impaired hearing and impaired vision. Resident uses walker and wheelchair.

The Negotiated Service Agreement (NSA) dated 7-7-16 stated:
Bathing: 1 assist 2 times a week.
Dressing: assist.
Hearing Aides: yes.
Glasses: yes
Toileting: self.
Transferring: assist.
Mobility: wheelchair.
Accompaniment: at times.
Medications: Self, CMA (Certified Medication Aide), RN (Registered Nurse). (Note: The NSA/HCSP lacked documentation of insulin pen being prepared by delegated certified medication aides for resident to self-inject.)

Resident Plan of Care Summary dated 12-29-16 recorded the following services:
Special Instructions: Everyone is aware on wound care instructions. Outside home health three times a week; Wound care, dressing changes per order; Outside wound health agency daily. Una boot right let 24 hours per day. Wound vac, (home health agency) is responsible for care, comes daily.

Hospital "After Visit Summary" dated 1-25-17 stated "Diagnoses this visit: Status Post Amputation of Great Toe, Right and Status Post Amputation of Lesser Toe Right."

Home Health Progress Note dated 2-23-17 stated the following:
Continue air mattress except for meals.
Continue heel protecting boot at all times.

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S5251	Continued From page 9 Continue home health. Dressing changes per home health. Keep dressing clean and dry. Nothing by mouth after midnight Monday night 2-27-17 for surgery on Tuesday morning 2-28-17. Follow up in wound clinic Wednesday 3-8-17. Finish Levaquin (antibiotic) as ordered... Interview on 4-10-17 at 3:15 pm with Operator stated resident went to hospital for outpatient procedure to have foot surgery (toe amputation). Confirmed the record lacked documentation of ongoing nursing assessments of resident's foot, date and time he/she left to go to the hospital for the procedure and return to the facility including assessments of dressing, wound and effectiveness of treatments. Operator unable to state what day resident had procedure done. Interview on 4-11-17 at 5:00 pm with Licensed Staff B confirmed he/she was unable to locate documentation of ongoing nursing assessment of resident's skin including lower extremities/feet; documentation of when resident went to hospital and what procedure was done, date, time and condition upon return to facility, effectiveness of treatments, monitoring of wound vac and visits by home health agency. For resident #411, the operator failed to ensure the record contained documentation of ongoing nursing assessments of resident's foot, date and time he/she left to go to the hospital for the procedure and date/time of return to the facility including ongoing assessments of dressing, wound and effectiveness of treatments.	S5251		
S5265 SS=D	26-42-205 (a) (1) Medication Self Administration Assessment	S5265		

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S5265	Continued From page 10 (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(a)(1) The facility reported a census of 9 residents. The sample included 3 residents. Based on record review and interview for 1 (#411) of 1 sampled residents taking insulin, the operator failed to ensure the licensed nurse performed an assessment to determine the resident's ability to safely inject insulin; and failed to ensure this assessment was completed initially before the resident began self-injection of insulin. Findings included: - Record review for resident #411 revealed admission on 7-7-16 with diagnoses Type 2	S5265		

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S5265	Continued From page 11 Diabetes Mellitus, Vitamin D Deficiency, Debility, Hyperlipidemia, Over Active Bladder, Insomnia and Hypertension. The Functional Capacity (FCS) screen dated 7-7-16 recorded resident independent with management of medications and treatments. The FCS failed to accurately reflect the resident's status in regard to medication and treatment management. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 7-7-16 stated: Medications: Self, CMA (Certified Medication Aide), RN (Registered Nurse). The NSA/HCSP lacked documentation of insulin pen being prepared by delegated certified medication aides for resident to self-inject. Physician's Orders dated 1-25-17 stated: Lantus Solostar 100 units/ml (milliliters) pen syringe, Inject 15 units subcutaneously at bedtime. Review of Medication Administration Record for April 2017 revealed: Lantus 15 "u" (units) at Bedtime. The record documented that resident self-administered the insulin. Interview on 4-10-17 at 11:10 am with Operator during completion of Entrance Tour Checklist stated there was one resident (#411) taking "Lantus (insulin) at night" and the staff prepared the insulin pen for resident to self-inject. Interview on 4-10-17 at 5:10 pm with Licensed Staff B confirmed the record lacked documentation of the resident's ability to safely inject insulin.	S5265		

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S5265	Continued From page 12 Interview on 4-11-17 at 12:47 pm with Certified Staff B stated he/she performed blood sugar monitoring and prepared the insulin pen for resident to self-inject nightly. For resident #411, the operator failed to ensure the licensed nurse performed an assessment to determine the resident's ability to safely inject insulin; and failed to ensure this assessment was completed initially before the resident began self-injection of insulin.	S5265		
S5300 SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility reported a census of 9 residents. The	S5300		

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S5300	Continued From page 13	S5300		

sample included 3 residents. Based on record review and interview for 2 (#411, #412) of 3 sampled residents, the operator failed to ensure all medications and biologicals were administered in accordance with a medical care provider's written order.

Findings included:

- Record review for resident #411 revealed admission on 7-7-16 with diagnoses Type 2 Diabetes Mellitus, Vitamin D Deficiency, Debility, Hyperlipidemia, Over Active Bladder, Insomnia and Hypertension.

The Functional Capacity (FCS) screen dated 7-7-16 recorded resident independent with management of medications and treatments. Note: The FCS failed to accurately reflect the resident's status in regard to medication and treatment management.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 7-7-16 stated: Medications: Self, CMA (Certified Medication Aide), RN (Registered Nurse).

Review of Medication Administration Record (MAR) for April 2017 revealed the following: Tramadol 50 mg (milligrams) by mouth every 6 hours as needed for pain.

Review of physician order dated 12-29-16: Tramadol 50 mg 1 tablet by mouth every 8 hours as needed for pain.

- Record review for Resident #412 revealed admission on 9-2-15 with diagnoses Dementia, Arthritis and Chronic Obstructive Pulmonary

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S5300	Continued From page 14 Disease. The Functional Capacity Screen (FCS) dated 4-12-16 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement (NSA) of unknown date stated: "Medications: CMA (Certified Medication Aide), RN (Registered Nurse)." Review of Medication Administration Record (MAR) for April 2017 revealed the following: Oxycodone 10/325 mg (milligrams) 1 tablet by mouth every 4 hours as needed for pain. Scheduled to be administered by certified staff at 8:00 am, 2:00 pm and 8:00 pm. Zofran (anti-nausea) 4 mg 1 tablet SL (sublingual) every 8 hours as needed for nausea. Tylenol 325 mg 2 tablets by mouth every 4 hours as needed for pain or elevated temperature. Physician orders stated: Oxycodone 10/325 mg 1 tablet by mouth every 4 hours as needed for pain. (to be administered on as needed basis, not scheduled). Zofran 4 mg tablet 1 table by mouth every 8 hours as needed for nausea. (not to be administered under the tongue). Tylenol 500 mg 1 or 2 tablets by mouth or suppository every 4 hours as needed for pain or elevated temperature. Interviews on 4-11-17 at 10:55 am with Operator and Licensed Staff B reviewed and confirmed the above discrepancies between physician orders and the Medication Administration Records for residents #411 and #412. For residents #411 and #412, the operator failed	S5300		

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	B006004	A. BUILDING: _____ B. WING _____	04/13/2017

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S5300	Continued From page 15 to ensure all medications and biologicals were administered in accordance with a medical care provider's written order.	S5300		
S5302 SS=D	26-42-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(4) The facility reported a census of 9 residents. The sample included 3 residents. Based on record review and interview for 1 (#411) of 1 sampled residents receiving insulin, the licensed nurse failed to appropriately delegate nursing procedures (as outlined under the Kansas nurse practice act) to certified medication aides (CMAs) related to the management and assistance with insulin injections for this resident. The licensed nurse failed to ensure documentation related to the delegation of this nursing task was included in the Residents' negotiated service agreements (NSA)/health care service plans (HCSP) and in the personnel files of each designated medication aide. Findings included: - Record review for resident #411 revealed admission on 7-7-16 with diagnoses Type 2	S5302		

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S5302	Continued From page 16 Diabetes Mellitus, Vitamin D Deficiency, Debility, Hyperlipidemia, Over Active Bladder, Insomnia and Hypertension. The Functional Capacity (FCS) screen dated 7-7-16 recorded resident independent with management of medications and treatments. The FCS failed to accurately reflect the resident's status in regard to medication and treatment management. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 7-7-16 stated: Medications: Self, CMA (Certified Medication Aide), RN (Registered Nurse). The NSA/HCSP lacked documentation of insulin pen being prepared by delegated certified medication aides for resident to self-inject. Physician's Orders dated 1-25-17 stated: Lantus Solostar 100 units/ml (milliliters) pen syringe. Inject 15 units subcutaneously at bedtime. Review of Medication Administration Record for April 2017 revealed: Lantus 15 "u" (units) at Bedtime. The record documented that resident self-administered the insulin. Interview on 4-10-17 at 11:10 am with Operator during completion of Entrance Tour Checklist stated there was one resident (#411) taking "Lantus (insulin) at night" and the staff prepared the insulin pen for resident to self-inject. Interview on 4-11-17 at 12:47 pm with Certified Staff B stated he/she performed blood sugar monitoring and prepared the insulin pen for resident to self-inject nightly. Certified Staff B confirmed he/she had worked at the facility for 1	S5302		

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S5302	Continued From page 17 ½ years and during that time had not been checked for competency prior to administering medications, preparing insulin pens and performing blood glucose monitoring. Certified Staff B correctly confirmed the unopened insulin pens were kept in the refrigerator until put in use, then stored with resident's medications at room temperature. Interview on 4-11-17 at 4:25 pm with Operator and Licensed Staff A stated resident #411 is the only resident currently receiving blood glucose monitoring and taking insulin and Certified Medication Aides perform the glucometers and prepare the insulin pen. Both confirmed the licensed nurse failed to appropriately delegate use of the insulin pen to certified medication aides. For resident #411, the licensed nurse delegated certified medication aides to prepare insulin pens and dial the insulin dose per physician's orders. The licensed nurse failed to appropriately delegate these nursing procedures to medication aides under the Kansas nurse practice act, K.S.A.65-1124 by ensuring documentation related to the delegation of this nursing task was included in the resident's plan of care and in the personnel files of each designated medication aide.	S5302		
S5328 SS=F	26-42-205 (l) (3) Medication Regimen Review Documentation (3) The administrator or operator, or the designee, shall ensure that the medication regimen review is kept in each resident ' s clinical record.	S5328		

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S5328	Continued From page 18 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(l)(3) The facility reported a census of 9 residents. The sample included 3 residents. Based on record review and interview for 3 (#410, #411, #412) of 3 sampled residents with medication regimen reviews and potentially affecting all residents, the operator failed to ensure that the medication regimen review is kept in each resident's clinical record. Findings included: - Record review for Resident #410 revealed admission on 4-15-16 with diagnoses Dementia with Lewy Bodies and Auditory Hallucinations, Hyperlipidemia, Depression, Edema, Muscle Weakness, Poly-Osteoarthritis and History of Falls. The Functional Capacity Screen (FCS) dated 4-6-17 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement (NSA) dated 4-6-17 stated: " Medications: CMA (Certified Medication Aide), RN (Registered Nurse). The record lacked documentation of a medication regimen review. - Record review for resident #411 revealed admission on 7-7-16 with diagnoses Type 2 Diabetes Mellitus, Vitamin D Deficiency, Debility, Hyperlipidemia, Over Active Bladder, Insomnia and Hypertension.	S5328		

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S5328	Continued From page 19 The Functional Capacity Screen (FCS) dated 7-7-16 recorded resident independent with management of medications and treatments. The FCS failed to accurately reflect the resident's status in regard to medication and treatment management. The Negotiated Service Agreement (NSA) dated 7-7-16 stated: "Medications: Self, CMA (Certified Medication Aide), RN (Registered Nurse)." The NSA/HCSP lacked documentation of insulin pen being prepared by delegated certified medication aides for resident to self-inject. The record lacked documentation of a medication regimen review. - Record review for Resident #412 revealed admission on 9-2-15 with diagnoses Dementia, Arthritis and Chronic Obstructive Pulmonary Disease. The Functional Capacity Screen (FCS) dated 4-12-16 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement (NSA) of unknown date stated: "Medications: CMA (Certified Medication Aide), RN (Registered Nurse)." The record lacked documentation of a medication regimen review. Interview on 4-11-17 at 10:25 am with Operator and Licensed Staff A stated the consulting pharmacist came quarterly to review resident records. When unable to provide documentation, the Operator called the pharmacy and requested	S5328		

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S5328	Continued From page 20 records of medication regimen reviews. The reviews were emailed to the Operator. Operator confirmed all records lacked documentation of medication regimen review. For residents #410, #411 and #412 and potentially affecting all residents, the operator failed to ensure that the medication regimen review is kept in each resident's clinical record.	S5328		
S5380 SS=E	28-39-437 Plumbing and Piping Systems (i) Plumbing and piping systems. (1) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (2) Water distribution systems shall be arranged to provide hot water at hot water outlets at all times. The temperature of hot water shall range between 98° F and 120° F at showers, tubs, and lavatories accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(i)(2) The facility reported a census of 9 residents. The sample included 3 residents. Based on observation and interview for all residents in the new addition to the facility, the operator failed to ensure the temperature of hot water shall range between 98 degrees Fahrenheit and 120 degrees Fahrenheit at showers, tubs and lavatories accessible to residents. Findings included: - Observation on 4-10-17 at 12:20 pm, during	S5380		

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S5380	Continued From page 21 entrance tour of facility accompanied by operator, revealed an area referred to as the "new addition" that was added after facility was purchased. This "addition" contained a shower room (no toilet or sink), laundry room, janitor closet with floor sink, and 4 resident rooms (two of which were shared). Two of the rooms shared a "Jack and Jill" bathroom (toilet and sink). Hot water temperatures in restroom sinks of resident rooms on this hall: Resident #412 restroom was 122.5 degrees F (Fahrenheit); Non-sampled Resident #404 restroom was 123.4 degrees F. Interview on 4-10-17 at 12:40 pm with Operator stated his/her spouse confirmed the hot water temperatures and "turned down" the hot water tank. At 3:30 pm, the Operator confirmed he/she does not have documentation of monitoring of the hot water temperatures. Stated "I just check it". - Observation on 4-11-17 at 11:30 am during recheck of hot water temperatures in the new addition revealed the following: Non-sampled resident #404 restroom was 131.1 to 133.1 degrees F. Resident #410 restroom sink was 127.5 degrees F. Tank was set on "Low" from being readjusted on 4-10-17. Interview on 4-11-17 at 11:30 am with Operator, confirmed the above hot water temperatures and stated the hot water tank was only 1 year old and had been turned down yesterday. Operator had staff turn off the hot water under the sinks in resident rooms until adjustments could be made; called in plumber and requested staff to check hot water hourly until it was at the correct	S5380		

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S5380	Continued From page 22 temperature. Operator's spouse came in and readjusted hot water tank then turned on all faucets to flush the tank. Operator stated he/she would check and document hot water temperatures weekly. Recheck of hot water temperatures at 12:07 pm revealed the following: Laundry room sink was 110.6 degrees F Non-sampled resident #404 restroom sink was 107.6 degrees F. Facility did not provide a policy for regular monitoring and documentation of hot water temperatures. For all residents in the new addition, the operator failed to ensure the temperature of hot water shall range between 98 degrees Fahrenheit and 120 degrees Fahrenheit at showers, tubs and lavatories accessible to residents.	S5380		