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HOME AGAIN SENIOR LIVING LLC	321 N MAIN STREET HAVILAND, KS 67059

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey of the above home plus facility on 3/15/17, 3/16/17, 3/20/17, and 3/21/17.	S 000		
S5155 SS=E	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) The facility reported a census of 9 residents. The sample included 3 residents. Based on record review and interview for 3 (#121, #122, and #123) of 3 residents sampled, the licensed nurse/operator B failed to ensure a licensed nurse provided or coordinated necessary health care services that met the needs of each resident. Findings included: - Record review for resident #121 revealed an admission date of 8/5/14 and diagnoses of history of stroke and arteriosclerotic heart disease. Functional capacity screen dated 7/28/16	S5155		

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

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indicated resident required physical assistance with bathing, dressing, toileting, transferring, mobility, and management of medications and treatments; was independent with eating; did not experience impaired cognition; and was at risk for falls.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 7/28/16 documented certified staff to assist with bathing, dressing, toileting, transferring, and administration of medications and treatments; mobility with motorized wheelchair; urinary catheter care; and "fall prevention 24/7." The NSA/HCSP lacked a description of interventions to address the resident's risk for falls.

Record contained documentation by resident's medical care provider on 1/9/17 of history of wound on resident's left lower leg and area now with redness and eschar on skin. Resident reports skin breakdown on buttocks. On 1/9/17 medical care provider ordered compression wrap to left lower leg and salt restriction and calorie restriction diet. Facility nurse responded to order that resident refused diet and compression wrap. Medical care provider denied changing this order.

Nurse's notes contained an entry by licensed nurse C at 3:13 p.m. on 3/7/17 that staff unable to accurately document sodium intake or calorie intake. Resident remains non-compliant with diet. Resident requests broth, tomato juice, and cinnamon rolls and eats snacks when out of facility. Resident complains that compression wrap to left lower is uncomfortable and request that wrap be removed.

NSA/HCSP lacked a description of the salt and calorie restricted diet and resident's refusal of the

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diet restrictions. NSA/HCSP lacked description of service of compression wrap to left lower leg. NSA/HCSP lacked interventions to address resident's risk for skin breakdown.

At 12:42 p.m. on 3/15/17, certified staff D stated resident had a pressure relieving cushion for motorized wheelchair but resident did not like to use the cushion. Certified staff D stated he/she applied Vaseline to resident's buttocks to protect skin and resident frequently changed positions by transferring from motorized wheelchair to recliner.

During an interview at 10:46 a.m. on 3/16/17, licensed nurse C stated interventions to address resident's risk for falls of call light button worn by resident, two-person transfer according to resident's instruction on how to transfer him/her, and resident to have shoes on when transferring. Licensed nurse C stated skin integrity interventions of compression wrap to left lower leg, peri-care, urinary catheter care 2 times a day, moisture barrier cream to bottom, and frequent transfers from motorized scooter to recliner. Licensed nurse C stated resident would at times demand compression wrap be removed from lower leg and refused to allow wrap to be reapplied. Licensed nurse C stated resident refused to sit on a gel cushion and refused to change position when in bed. Licensed nurse C stated resident refused to be compliant with salt and calorie restricted diet. Licensed nurse C confirmed the resident's NSA/HCSP lacked interventions to address resident's risk for falls, measure to prevent skin breakdown, and need to monitor salt and calorie intake.

Licensed nurse/operator B failed to ensure a licensed nurse provided or coordinated necessary health care services that met the needs of

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resident #121.

- Record review for resident #122 revealed an admission date of 1/16/17 and diagnoses of diabetes mellitus and congestive heart failure.

Functional capacity screen dated 1/10/17 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; did not experience impaired cognition; and was at risk for falls.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 1/10/17 "fall prevention 24/7." NSA/HCSP lacked interventions to address resident's risk for falls.

Nurse's notes contained documentation of falls experienced by resident as follows:

2/9/17 at 9:03 p.m. certified staff F documented resident's foot caught on floor trim between bathroom tile and bedroom carpet while walking with resident back from bathroom. Resident fell to knees. On-call nurse notified.

2/21/17 at 10:30 p.m. certified staff G documented resident on floor at end of bed. Resident stated he/she was sitting on edge of bed reaching for door to bathroom, lost balance and slid off bed.

Licensed nurses C documented an assessment of resident after each fall and documented interventions of staff to check on resident regularly and remind resident to use call light for assistance when up.

On 3/15/17 at 3:27 p.m. certified staff D stated he/she assisted resident to walk using a gait belt

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and kept 2 hands on resident when walking because resident's knee would give out.

At 10:37 a.m. on 3/16/17, licensed nurse C stated interventions to address resident's risk for falls as remind resident to use call light, assist ambulation with gait belt, and toileting assistance.

Licensed nurse/operator B failed to ensure a licensed nurse provided or coordinated necessary health care services that met the needs of resident #122.

- Record review for resident #123 revealed an admission date of 6/1/13 and a diagnosis of multiple sclerosis.

Functional capacity screen dated 5/10/16 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; did not experience impaired cognition; and was at risk for falls.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 5/10/16 documented service of "fall prevention on-going"

Nurse's notes contained documentation of falls experienced by resident:

5/6/16 (no time documented) licensed nurse C documented aide called nurse to report resident fell in bathroom while sitting on toilet. Nurse documented assessment.

2/6/17 at 7:09 p.m. licensed nurse C documented staff reports resident fell and cut forehead. Nurse documented small pea-sized cut to forehead, bleeding, and bruise surrounding area. Instructed resident to notify staff if dizzy or has blurred

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S5155	Continued From page 5 vision. Call light in reach of resident. At 3:25 p.m. on 3/15/17, certified staff D stated one person could transfer resident but two people transferred resident since resident's legs would at times give out causing resident to fall. During an interview at 10:25 a.m. licensed nurse C listed interventions to address resident's risk for falls as call light in reach, remind resident to use call light when needs to get up, and staff member to stay in resident's room when resident on toilet. Licensed nurse C stated the interventions were not in the NSA/HCSP. Licensed nurse/operator B failed to ensure a licensed nurse provided or coordinated necessary health care services that met the needs of resident #123.	S5155		
S5205 SS=J	26-42-104 (a) Disaster and Emergency Preparedness a) The administrator or operator of each home plus shall ensure the provision of a sufficient 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 reported a census of 9 residents. The sample included 3 residents. Based on record review, interview, and observations for 1 (#121) of 1 resident requiring two-person transfer assistance, licensed nurse/operator B failed to	S5205		

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S5205	Continued From page 6	S5205		

ensure the provision of a sufficient number of qualified staff members to take resident #121 to a secure location in the event of an emergency or disaster when only 1 staff member was scheduled from 11:00 p.m. to 7:00 a.m. This failure placed resident #121 in immediate jeopardy for harm or death.

Findings included:

- At 11:40 a.m. on 3/15/17, licensed nurse/operator B stated 2 certified staff members worked the 7:00 a.m. to 3:00 p.m. shift and 2 certified staff members worked 3:00 p.m. to 11:00 p.m. shift with only 1 certified staff member on duty for the 11:00 p.m. to 7:00 a.m. shift. Licensed nurse/operator B stated he/she had not conducted an emergency drill with one employee taking all residents to a secure location.

Review of the resident roster revealed resident #121 required two-person assistance to transfer.

Record review for resident #121 revealed an admission date of 8/5/14 and diagnoses of history of stroke and arteriosclerotic heart disease.

Functional capacity screens dated 7/20/15 and 7/28/16 each indicated resident required physical assistance with transferring. Negotiated service agreement/health care service plans dated 7/20/15 and 7/28/16 each documented "Staff will provide assist with all transfers at all times."

At 12:52 p.m. on 3/15/17 observed resident #121 mobilize self in facility in a motorized wheelchair.

At 3:20 p.m. on 3/15/17, when asked how much assistance each resident in facility would need to

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exit the building in an emergency, certified staff D stated the following:

Resident #121 two people to transfer resident to motorized wheelchair that resident operated independently.

Resident #123 one to two-person assistance to transfer to motorized wheelchair that resident operated independently. Certified staff D stated two people transferred resident due to not knowing when resident's legs would give out.

Resident #122 required one person to transfer and mobilize wheelchair.

Resident #127 one person to transfer resident to wheelchair and resident could mobilize wheelchair.

Resident #125 required one person to transfer and one person to walk with resident due to resident's unsteadiness.

Residents #120, #124, #126, and #128 independent with transfer and ambulation.

At 3:47 p.m. on 3/15/17, licensed nurse/operator B stated he/she went to a schedule of 1 certified employee on duty on the 11:00 p.m. to 7:00 a.m. shift on 12/7/15 when another resident who required two people to transfer died. Licensed nurse/operator B stated after resident #121 went to bed at night resident did not get out of bed until morning. Licensed nurse/operator B agreed one person likely could not get resident to a safe place in an emergency or disaster.

At 4:34 p.m. on 3/15/17, informed licensed nurse/operator B staffing pattern of one certified

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person on duty from 11:00 p.m. to 7:00 a.m. placed resident #121, who required two-person physical assistance to transfer, in immediate jeopardy for harm or death.

During an interview in resident #121's room at 11:09 a.m. on 3/16/17, resident #121 stated "You know it takes 2 people to transfer me." Resident pointed to a grab bar attached to the wall and explained certified staff wheeled resident up to the grab bar; 2 people assisted resident to stand to hold onto grab bar; one person supported resident to stand while second person wheeled whatever piece of furniture/equipment resident was in away from resident and wheeled up to resident whatever piece of furniture/equipment resident was to get into. Resident stated there were wheels on recliner, commode, and hospital bed. Resident stated he/she had a stroke that affected left arm and leg and that he/she could not stand on legs for long without assistance to stand.

At 11:47 a.m. on 3/16/17 in the room of resident #121, observed certified staff D and certified staff E transfer resident from recliner to motorized wheelchair. Certified staff D rolled resident who was sitting in the recliner to the grab bar on the wall and both employees assisted resident to stand and use right hand to hold the grab bar. Certified staff E supported resident to stand while certified staff D pushed recliner out of way and guided motorized wheelchair up behind resident and both employees assisted resident to sit in motorized wheelchair. Surveyor observed resident's left hand contracted at wrist with fingers curled and resident unable to use left arm during transfer.

Licensed nurse/operator B failed to ensure the

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S5205	Continued From page 9 provision of a sufficient number of qualified staff members to take resident #121 to a secure location in the event of an emergency or disaster when only 1 staff member was scheduled from 11:00 p.m. to 7:00 a.m. The immediate jeopardy was corrected at 5:01 p.m. on 3/15/17 when licensed nurse/operator B provided a written plan to ensure 2 qualified staff on duty on the 11:00 p.m. to 7:00 a.m. shift.	S5205		
S5215 SS=E	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: (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 reported a census of 9 residents. The sample included 3 residents. Based on record review and interview for all residents and all	S5215		

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S5215	Continued From page 10 employees, licensed nurse/operator B failed to ensure disaster and emergency preparedness by ensuring a quarterly review of the facility's emergency management plan. Findings included: - Review of facility documentation of quarterly reviews of the emergency management plan with residents and employees revealed the lack of any reviews in 2016. At 11:51 a.m. on 3/15/17, licensed nurse/operator B stated he/she could not locate documentation that the plan was reviewed with residents and employees in 2016. Licensed nurse/operator B failed to ensure disaster and emergency preparedness by ensuring a quarterly review of the facility's emergency management plan with all residents and all employees.	S5215		
S5267 SS=D	26-42-205 (a) (3) Self Administration Assessment documented (a) (3) The resident ' s clinical record shall contain documentation of the assessment and the determination. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(a)(3) The facility reported a census of 9 residents. The sample included 3 residents. Based on record review and interview for 1 (#122) of 1 resident self-injecting insulin, the licensed nurse failed to	S5267		

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ensure the resident's clinical record contained documentation of the resident's ability to safely and accurately self-administer insulin injections.

Findings included:

- Record review for resident #122 revealed an admission date of 1/16/17 and diagnoses of diabetes mellitus and congestive heart failure.

Functional capacity screen dated 1/10/17 indicated resident required physical assistance with medication management.

Negotiated service agreement/health care service plan dated 1/10/17 documented "Facility will administer medications except for insulin. Resident will continue to administer own insulin."

March 2017 medication administration record contained documentation that resident self-administered insulin two times a day with insulin pen provided to resident by certified medication aide or licensed nurse.

Resident's clinical record lacked documentation of a licensed nurse assessment of the resident's ability to self-administer insulin.

At 4:09 p.m. on 3/15/17, licensed nurse C stated he/she assessed resident's ability to self-administer insulin at admission to the facility but did not document the assessment in the resident's record.

Licensed nurse failed to ensure resident #122's clinical record contained documentation of the resident's ability to safely and accurately self-administer insulin injections.

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S5300	Continued From page 12	S5300		
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 sample included 3 residents. Based on record review and interview for 2 (#121 and #122) of 3 residents sampled, the licensed nurse/operator B failed to ensure certified medication aides administered medications ordered on an as needed basis to residents in accordance with professional standards of practice. Findings included: - Record review for resident #121 revealed an admission date of 8/5/14 and diagnoses of history	S5300		

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S5300	Continued From page 13 of stroke and arteriosclerotic heart disease. Functional capacity screen dated 7/28/16 indicated resident required physical assistance with management of medications and medical treatments. Negotiated service agreement/health care service plan dated 7/28/16 documented service of licensed nurse or certified medication aide will administer all medications and treatments as ordered by medical care provider. Review of the March 2017 medication administration record revealed certified medication aides (CMAs) administered the following medications and treatments to the resident on an as needed basis: Alprazolam (anti-anxiety medication) 0.25 milligram (mg) every 4 hours as needed for anxiety. Record documented CMAs administered this medication to resident every night 3/1/17 through 3/14/17 between 9:50 p.m. and 10:29 p.m. Mirapex 0.5 mg as needed at bedtime for restless leg symptoms. Record documented CMAs administered this medication to resident every night 3/1/17 through 3/14/17 between 9:51 p.m. and 10:30 p.m. Duoneb HHN (hand held nebulizer to deliver medication to prevent bronchospasm) every 4 hours as needed. Record documented CMAs administered this treatment to resident on March 5,7, 8, 9, 11, 12, 13, and 14, 2017 one time each evening. Robitussin DM 1 teaspoon every 4 to 6 hours as	S5300		

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(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
S5300	Continued From page 14	S5300		

needed for cough. Record documented CMAs administered this medication to resident on March 5, 7, 8, 9, 11, 12, 14, 2017 one time each evening.

The resident's record lacked documentation of a licensed nurse assessment of resident prior to CMAs administering these medications and treatment.

At 11:00 a.m. on 3/16/17, licensed nurse C stated CMAs did not notify licensed nurse to assess resident prior to administering medication/treatment to resident on an as needed basis.

Licensed nurse/operator B failed to ensure certified medication aides administered medications/treatment ordered on an as needed basis to resident #121 in accordance with professional standards of practice.

- Record review for resident #122 revealed an admission date of 1/16/17 and diagnoses of diabetes mellitus and congestive heart failure.

Functional capacity screen dated 1/10/17 indicated resident required physical assistance with management of medications.

Negotiated service agreement/health care service plan dated 5/10/16 documented service of licensed nurse or certified medication aide will administer all medications except for insulin to resident.

The March 2017 medication administration record documented a certified medication aide administered Miralax (laxative) 17 grams to resident on 3/3/17. Resident's record contained a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B049001	A. BUILDING: _____ B. WING _____	03/21/2017

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S5300	Continued From page 15 medical care provider's order for Miralax 17 grams as needed for constipation. Resident's record lacked documentation of a licensed nurse assessment prior to the administration of Miralax. At 10:45 a.m. on 3/16/17, licensed nurse C stated certified medication aides did not notify a licensed nurse for assessment of resident prior to administering medications ordered on an as needed basis. Licensed nurse/operator B failed to ensure certified medication aides administered medication ordered on an as needed basis to resident #122 in accordance with professional standards of practice.	S5300		