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	B087216	A. BUILDING: _____ B. WING _____	R 01/04/2017

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GOLDEN BOOMERS HOME PLUS, LLC	6953 E KENTFORD CIRCLE WICHITA, KS 67226

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{S 000}	INITIAL COMMENTS The following citations represent the findings of a revisit for correction order 16-72 of the above home plus facility on 1/3/17 and 1/4/17.	{S 000}		
S5301 SS=E	26-42-205 (d) (3) Facility Administration of Medications (d) (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(3)(C)(D) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review, observation, and interview for 1 (#1070) of 3 residents sampled and 1 (#1060) non-sampled resident, the operator/certified medication aide (CMA) C failed to ensure a CMA remained with each resident until medications were ingested and the CMA that administered	S5301		

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

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medications to resident documented administration of medications immediately before or following completion of the task.

Findings included:

- Record review for resident #1070 revealed an admission date of 8/30/16 and diagnoses of Alzheimer's disease, mood disorder, and hypertension. Functional capacity screen dated 12/7/16 indicated resident was unable to perform management of medications and experienced impaired short-term memory, long-term memory, decision making, and memory recall. Negotiated service agreement/health care service plan dated 12/8/16 documented the service of medication management by licensed staff.

At 12:28 p.m. on 1/3/17, observed CMA B place a medication cup filled with numerous medication tablets on the kitchen table in front of resident #1070. CMA B walked away from resident and returned to preparing meal for other residents. CMA B then returned to resident #1070, instructed resident to take medications, and walked away from resident. Resident #1070 removed several medications from cup and placed medications on table to right of plate of food and removed remaining medications from cup and placed on a napkin on left side of plate. Resident #1070 then began picking up medications and placing in his/her mouth. Observed that resident at three separate times dropped medication tablets on self and each time retrieved the tablets and ingested. Resident then dropped a tablet on the floor. Resident #1030 informed CMA B that resident (#1070) dropped a medication. CMA B picked the tablet up from the floor, placed the tablet on the table in front of resident, and told resident "You need to take

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S5301	Continued From page 2	S5301		

that." Surveyor informed CMA B that medication had been on the floor and to notify licensed nurse for further instruction. CMA B placed the medication in a medication cup and provided the bubble pack of divalproex 250 milligram tablets to identify the medication dropped on the floor. CMA B confirmed the medications provided to the resident at 12:28 p.m. were medications listed as 8:00 a.m. medications on the medication administration record. CMA B texted the licensed nurse to inform resident did not receive divalproex and ask for further instructions.

Review of the resident's January 2017 medication administration record revealed resident #1070 to receive the following medications at 8:00 a.m.

Lasix (diuretic) 20 milligrams (mg) 1 tablet by mouth daily

Norvasc (antihypertensive) 2.5 mg 1 tablet by mouth daily

Zyprexa (antipsychotic) 2.5 mg 1 tablet by mouth daily

Zestril (antihypertensive) 40 mg 1 tablet by mouth daily

Divalproex (for mood disorder) 250 mg 1 tablet by mouth 2 times a day

Namenda (to treat dementia) 10 mg 1 tablet by mouth 2 times a day

Potassium Chloride (supplement) 20 milliequivalents 1 tablet by mouth 2 times a day

The January medication administration record lacked documentation that the resident received

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S5301	Continued From page 3	S5301		

the above medications on 1/2/17.

At 12:41 p.m. on 1/3/17, CMA B stated he/she "usually stayed" with resident until resident ingested all medications. CMA B confirmed he/she did not remain with resident #1070 until all medications were ingested by the resident. CMA B stated (operator/CMA C) administered 8:00 a.m. medications on 1/2/17.

During an interview at 2:00 p.m. on 1/3/17, operator/CMA C stated he/she administered medications to resident 1/2/17 and did not initial on the medication administration record at the time. Operator/CMA C stated he/she just now initialed the medications. Operator/CMA C confirmed CMA administering medications to remain with resident until medications ingested.

Operator/certified medication aide C failed to ensure a CMA remained with each resident until medication were ingested and CMA administering medications to resident documented administration of medications immediately before or following completion of the task.

- At 11:50 a.m. on 1/3/17, observed resident #1060 sitting at a table in the dining room/kitchen area. A plate of food and an empty medication cup were on the table in front of the resident.

At 12:21 p.m. on 1/3/17, observed CMA B pick up the plate in front of resident #1060 and CMA B found a pill on the table. CMA B placed the pill on the resident's spoon and told resident "You need to take this." Resident #1060 took the spoon and ingested the medication.

Review of the resident roster revealed resident #1060 required facility management of

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S5301	Continued From page 4 medications and resident experienced impaired cognition. Operator/CMA C failed to ensure a CMA remained with each resident until medication was ingested.	S5301		
S5315 SS=E	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer '	S5315		

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S5315	Continued From page 5 s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h)(1) The facility reported a census of 5 residents. The sample included 3 residents. Based on observation, interview, and record review for all residents, operator/certified medication aide (CMA) C failed to ensure a CMA stored all medications securely in a locked medication cart with only the CMA having access to medications. Findings included: - At 11:50 a.m. on 1/3/17 an employee (CMA B) answered the front door of the facility and introduced self as a CMA and the only employee on duty. Observed resident #1060 and resident #1050 sitting in the open kitchen/dining room area and a medication cart placed at the end of the kitchen counter. Observed an open door to the room of resident #1070 and that resident was sitting on edge of bed with a personal alarm attached to resident. CMA B went to the room of resident #1070 and closed the door to provide care to resident. At 11:58 a.m. on 1/3/17, while CMA B remained in the resident #1070's room, observed resident #1050 get up from a chair at the table closest to the medication cart and walked out of the room. Observed the medication cart was unlocked. Opened drawers of the cart and observed medications for all residents. Observed 3 medication cups in the top drawer of the cart with	S5315		

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S5315	Continued From page 6 each cup labeled with the name of a resident and medication tablets/capsules in the cups. At 12:02 p.m. CMA B returned to the kitchen/dining area and locked the medication cart. At 12:09 p.m. on 1/3/17 CMA B returned to resident #1070's room. On top of the medication cart observed an open package containing a Lidocaine (topical anesthetic) patch with the handwritten name of resident #1060 and "left leg" and on the patch handwriting of 1/3/17. At 12:21 p.m. on 1/3/17, CMA B returned to the medication cart and stated he/she had removed the patch from the medication cart to apply to resident #1060. CMA B confirmed he/she had not stored medications in a locked medication cart at all times when CMA B not at the medication cart. During time in the facility on 1/3/17, observed residents #1030, #1050, and #1080 each independent with mobility. Review of the resident roster revealed all 5 residents living in the facility experienced impaired cognition. Operator/CMA C failed to ensure a CMA stored all medications securely in a locked medication cart with only the CMA having access to medications.	S5315		
S5316 SS=D	26-42-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the	S5316		

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S5316	Continued From page 7 destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(i)(2)(A)(B)(C)(D) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review, observation, and interview for 1 (#1070) of 3 residents sampled, the licensed nurse failed to ensure destruction of the resident's non-controlled medication by two licensed nurses; a licensed nurse and a medication aide; a licensed nurse and a licensed pharmacist; or a medication aide and a licensed pharmacist. Findings included: - Record review for resident #1070 revealed an	S5316		

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S5316	Continued From page 8	S5316		

admission date of 8/30/16 and diagnoses of Alzheimer's disease, mood disorder, and hypertension. Functional capacity screen dated 12/7/16 indicated resident was unable to perform management of medications and experienced impaired short-term memory, long-term memory, decision making, and memory recall. Negotiated service agreement/health care service plan dated 12/8/16 documented the service of medication management by licensed staff.

At 12:28 p.m. on 1/3/17, observed CMA B place a medication cup filled with numerous medication tablets on the kitchen table in front of resident #1070. CMA B walked away from resident and returned to preparing meal for other residents. CMA B then returned to resident #1070, instructed resident to take medications, and walked away from resident. Resident #1070 removed several medications from cup and placed medications on table to right of plate of food and removed remaining medications from cup and placed on a napkin on left side of plate. Resident #1070 then began picking up medications and placing in his/her mouth. Observed that resident at three separate times dropped medication tablets on self and each time retrieved the tablets and ingested. Resident then dropped a tablet on the floor. Resident #1030 informed CMA B that resident (#1070) dropped a medication. CMA B picked the tablet up from the floor, placed tablet on table in front of resident, and told resident "You need to take that." Surveyor informed CMA B that medication had been on the floor and to notify licensed nurse for further instruction. CMA B placed the medication in a medication cup and provided the bubble pack of divalproex (to treat mood disorder) 250 milligram tablets to identify the medication dropped on the floor. CMA B texted the licensed

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S5316	Continued From page 9 nurse to inform resident did not receive divalproex and ask for further instructions. During a phone interview at 1:53 p.m. on 1/3/17, licensed nurse D stated he/she instructed (CMA B) to throw the divalproex tablet away. Licensed nurse D stated he/she was not aware of procedure for licensed nurse and CMA to destroy medication and document the destruction. At 2:00 p.m. on 1/3/17, operator/CMA C stated he/she was not aware of procedure for licensed nurse and CMA to destroy medication and document the destruction. The licensed nurse failed to ensure destruction of resident #1070's non-controlled medication by two licensed nurses; a licensed nurse and a medication aide; a licensed nurse and a licensed pharmacist; or a medication aide and a licensed pharmacist.	S5316		
{S5380} SS=F	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)	{S5380}		

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{S5380}	Continued From page 10 The facility reported a census of 5 residents. The sample included 3 residents. Based on observation, interview, and record review for all residents living in the facility, the operator failed to ensure a hot water temperature range between 98 degrees Fahrenheit (F) and 120 degrees F at showers and lavatories accessible to residents. Findings included: - At 11:56 a.m. on 1/3/17, obtained a hot water temperature of 88.7 degrees F from the sink in bathroom #1 and 82.7 degrees F from the salon bathroom sink. At 12:05 p.m. obtained a hot water temperature reading of 78.9 degrees F from the kitchen sink. Certified medication aide (CMA) B stated he/she had hot water when washing dishes by hand and had not given showers to residents that morning. Between 12:00 p.m. and 1:30 p.m. on 1/3/17, observed residents #1030, #1050, and #1080 independently go into bathroom #1. Review of the resident roster revealed each resident experienced impaired cognition and resident #1030 was independent with bathing. Operator/CMA C arrived at facility at 1:34 p.m. on 1/3/17 and provided documentation of hot water temperature readings. Operator/CMA C explained night shift staff person measured and recorded hot water temperature and was to do this every night. Review of the readings revealed out of range temperatures as follows: 12/9/16 bathroom #2 at 134 degrees F and employee notified nurse and lowered hot water tank thermostat. 12/10/16 salon bathroom 123.8 degrees F,	{S5380}		

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{S5380}	Continued From page 11 employee notified nurse and lowered thermostat on hot water tank. 12/11/16 salon bathroom 125.2 degrees F, employee documented "N/A" (not applicable) in the column labeled "What did you do?" and the column labeled "Who did you notify?" 12/12/16 salon bathroom 128.1 degrees F and bathroom #2 at 122.3 degrees F with N/A written for action taken and person notified. 12/14/16 kitchen 122 degrees F with N/A written for action taken and person notified. 12/16/16 kitchen 146.6 degrees F, salon bathroom 143.2 degrees F, and bathroom #2 at 141.8 degrees F. Employee documented he/she notified nurse and lowered thermostat on hot water tank. 12/27/16 kitchen 128.7 degrees F, salon bathroom 130.2 degrees F, and 128.5 degrees F in bathroom #2. Employee documented nurse notified and thermostat lowered. 12/30/16 kitchen 126.4 degrees F, salon bathroom 127.6 degrees F, and 128.3 degrees F in bathroom #2. Employee documented nurse notified and thermostat lowered. The documentation lacked follow-up hot water temperature readings after adjustment of thermostat on hot water tank. At 1:38 p.m. on 1/3/17, operator/CMA confirmed hot water temperatures were not maintained between 98 degrees F and 120 degrees F at showers and lavatories accessible to residents. Operator/CMA C stated he/she did not know what	{S5380}		

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{S5380}	Continued From page 12 to do to ensure hot water temperature in safe range for residents. At 4:00 p.m. on 1/3/17, operator/CMA C stated a plumber would be at the facility between 5:00 p.m. and 6:00 p.m. on 1/3/17 with possibility of installing a new hot water heating system. For all residents living in the facility, the operator failed to ensure a hot water temperature range between 98 degrees F and 120 degrees F at showers and lavatories accessible to residents.	{S5380}		