STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089030	A. BUILDING: _____ B. WING _____	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE WEST	3515 SW 6TH AVENUE TOPEKA, KS 66606

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S 000	INITIAL COMMENTS The following citations are the result of a licensure abbreviated survey at the above named assisted living facility in Topeka, Kansas on 12/15/16, 12/20/16, 12/21/16 and 12/22/16. Revised 2567 sent to facility 12/23/16.	S 000		
S 115 SS=F	26-39-103 (d) Resident Right Inspection of Records (d) Inspection of records. (1) The administrator or operator shall ensure that each resident or resident's legal representative is afforded the right to inspect records pertaining to the resident. The administrator or operator, or the designee, shall provide a photocopy of the resident's record or requested sections of the resident's record to each resident or resident's legal representative within two working days of the request. If a fee is charged for the copy, the fee shall be reasonable and not exceed actual cost, including staff time. (2) The administrator or operator shall ensure access to each resident ' s records for inspection and photocopying by any representative of the department. This STANDARD is not met as evidenced by: KAR-39-103 (d) (2) The census equaled 30 residents the sample included 6 residents and 2 closed chart review residents. Based on interviews and record reviews for all residents, the operator failed to ensure independent direct access to each resident ' s electronic records for inspection and further failed to provide facility monitored direct access to each resident ' s electronic record by a representative of the department to validate all entries in the electronic record were included in	S 115		

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

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S 115	Continued From page 1 the printed report. Findings included: On 12/15/16 at 10:50am, access to electronic resident records (nurses notes are recorded electronically) was requested. Access was denied by facility operator #Z. He/she stated " we will print anything you want. " Printed copies of nurses notes received contain only a run date in the heading of the document; the report does not verify the date range included in the report. On 12/20/16 at 10:15 am requested access to view resident electronic records (nurses notes) on electronic system, with another nurse or staff member present. Access denied by facility operator #Z. He/she stated there is no way to not see proprietary information while getting to nurses notes. He/she would check on it. No permission for access to records given as of 12/2016 at 6:30pm. For all residents, the operator failed to ensure independent direct access to each resident ' s electronic records for inspection and further failed to provide facility monitored direct access to each resident ' s electronic record by a representative of the department.	S 115		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the	S3026		

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S3026	Continued From page 2 following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 30 residents. The sample included 6 residents and 2 closed record reviews. Based on record review and interview for 4 (#1218, #1219, #1220, and #1221) of 6 sampled residents, the operator failed to ensure the resident was not subjected to neglect when facility staff continued to allow administration of medication by someone other than the licensed nurse and certified medication aides for residents who required facility management of medication and further failed to provide services reasonably necessary to ensure resident ' s safety and well-being and to avoid harm when the nurse failed to properly obtain accurate medication records and physicians confirmation orders for residents ' medications and treatments when facility began medication administration previously provided by outside providers. Resident #1218 failed to receive medications with serious risks associated with abrupt discontinuance, placing this resident in immediate jeopardy for harm, injury and death. Findings included: Resident #1218 was admitted on 8/22/14 with diagnoses of GERD (gastrointestinal reflux), osteoporosis, atrial fibrillation, congestive heart	S3026		

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S3026	Continued From page 3	S3026		

failure, hypertension, chronic obstructive pulmonary disease, depression and coronary artery disease.

FCS (functional capacity screen) dated 10/3/16 recorded resident had no impairment in cognition, was independent with all activities of daily living and required assistance with management of medication. FCS dated 12/5/16 recorded resident with impaired short term memory, long term memory, and memory recall.

NSA/HCSP (negotiated service agreement/health care service plan) dated 10/14/16 documented outside agency provided medication management; revised NSA/HCSP dated 12/5/16 documented facility staff will administer all medications to resident.

Interview with outside agency staff on 12/21/16 stated prior to 12/1/16, a family member was setting up resident ' s medication in a pill minder box and outside agency staff were reminding resident to take medication.

Review of record included a medication administration record (MAR) dated 12/1/16 through 12/14/16 listing medications taken from physician order sheet for 10/15/16 through 11/14/16 signed by the medical care provider on 11/15/16. The MAR lacked documentation of Gabapentin (for neuropathy) and Xarelto (anticoagulant).

Physician visit sheet dated 7/26/16 documented the resident was to be started on Xarelto 15 mg (milligrams) daily and increased the Gabapentin dose.

Nurses notes dates 7/26/16 documented " . . .

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S3026	Continued From page 4 Xarelto 15 mg po every day with meal . . .family sets up med box and outside agency does med reminders " Nurses note 10/24/16 documented " Resident seen by physician . . .start Gabapentin 100 mg by mouth TID (three times a day) for 3 days then 300 mg by mouth BID (two times a day). . . " Nurses note 11/11/16 documents " new order to increase Gabapentin to 300 mg TID, orders transcribed, family member notified. " Nurses notes for 11/17/16 written in 12/5/16 documents " self medication assessment completed with resident. . .he/she could not recall what he/she is taking his/her medication for and could not recall the times of when to take his/her medication. Resident is currently receiving services with medication through outside agency. Resident will be on Atria ' s medication program starting 12/1/16. Nurses note for 11/22/16 10 a.m. written on 12/7/16 documents " increase gabapentin to 400 mg TID x 3 days then 500 mg TID for 3 days then 600 mg TID. Start Duoneb QID (4 times per day), continue Albuterol nebulizer every 4 hours as needed. Nurses note 12/8/16 at 4:30 p.m. documented meeting with resident ' s family regarding change in medication management. Resident record failed to document review of current medication list with family member setting up resident ' s medications on 11/30/16 and failed to seek clarification from the medical care provider regarding orders of Gabapentin and Xarelto.	S3026		

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S3026	Continued From page 5 Medication administration record for 12/1/16 through 12/14/16 recorded Oxycodone hydrochloride 5 mg (milligrams) (a narcotic pain medication) 1 tablet by mouth every 6 hours as needed. Initialed as given by certified staff #X on 12/6/16 and by certified staff #W on 12/9/16 with notation of reason as " pain " . Nurses notes lacked documentation of an assessment and lacked follow up assessment related to the resident ' s complaint of pain. Nurses notes dated 12/9/16 at 2 p.m. documented that staff reported resident complained of not feeling well and was complaining of neck and cervical pain. Resident was sent to the hospital at family ' s request. Nurses notes lacked documentation of an assessment of the resident. Resident was hospitalized from 12/9/16 to 12/11/16 with increased confusion, agitation and weakness. Admission history and physical notes document assessment: " This resident has altered mentation due to improper doses of his/her medicines either by omission or commission. He/She is not clear what he/she did or did not take. " Resident #1218 did not receive Gabapentin or Xarelto from 12/1/16 to 12/9/16. Xareltohcp.com stated stopping Xarelto prematurely can be fatal with increased risk for blood clots and increase risk for stroke when not transitioned to another adequate anticoagulant.	S3026		

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S3026	Continued From page 6 Drugs.com documented if gabapentin dose is reduced or discontinued it should be done gradually over a week. Abruptly discontinuing Gabapentin may result in side effects such as anxiety, insomnia, nausea, pain, and sweating. Resident #1218 failed to received gabapentin and xarelto for 9 days and was assessed with a change in cognition after missing the medications for 5 days. Resident #1218 requested narcotic pain medication on 12/6/16 and 12/9/16 for complaints of pain. Resident #1218 was not assessed by a nurse related to his/her complaints of pain and the record lacked documentation of assessments related to the change in cognition. For resident #1218, the licensed nurse failed to ensure medications were administered in accordance with professional standards of practice when the licensed nurse failed to review the current medications the resident received with the family member who assisted with his/her medications, relied on an outdated list of medications in the record, and failed to reconcile additional orders documented in the nurses notes. The resident did not receive 2 medications that have serious risks associated with abrupt discontinuance. These failures placed resident #1218 in immediate jeopardy for harm, injury or death. The jeopardy was corrected when the resident was admitted to the hospital on 12/9/16 and facility staff completed chart audits to ensure residents were receiving medications as ordered. Record review for resident #1220, admitted 10/29/14 documented diagnoses of abdominal	S3026		

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pain, nausea and vomiting, esophagitis, vitamin B12 deficiency, hyperlipidemia, hypertension, dementia, hypothyroidism.

FCS dated 8/5/16 documented resident required assistance with medication management.

NSA/HCSP dated 10/9/16 did not document service for medication management and 12/5/16 documented facility staff to administer all medications.

Nurses notes written on 12/5/16 documented 11/17/16 at 2:54 p.m. " self medication assessment completed with resident at this time. Resident could not communicate what medication he/she was receiving or what the medications were for. Resident is currently receiving services through [outside agency] at this time. Atria staff will be administering medication to this resident starting 12/1/2016. "

Comparison of list of medication administered by the outside agency on 11/30/16 and 12/1/16-12/14/16 MAR for resident #1220 revealed the following discrepancies:

Medications identified as administered by outside agency on 11/30/16 that were not listed as administered by facility staff on 12/1/16 through 12/14/16 MAR:
- Donepezil HCL F/C 5 mg (for Alzheimer ' s disease) 1 tablet at HS (Hour of sleep)
- Multivitamin 1 daily
- Alendronate sodium 70 mg(for osteoporosis) 1 tablet weekly on Sunday
- Calcium 500 mg 1 tablet daily
- Vitamin D-3 2000 units 1 daily

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S3026	Continued From page 8 Medications identified as administered by outside agency on 11/30/16 with different dose listed as administered by facility staff on 12/1/16 through 12/14/16 MAR: - Pravastatin Sodium 40 mg (for elevated cholesterol) 2 tabs at HS with facility MAR documenting only 1 tab administered Medications listed on facility MAR as administered from 12/1/16 through 12/14/16 that were not administered by outside agency on 11/30/16: -Citalopram HBR 20 mg (for depression and anxiety) 1 tablet daily - Rivastigmine 13.3 mg 24hour patch (for Alzheimer ' s/dementia) daily -Pantoprazole sodium f//c 40 mg 1 tablet twice daily before meals Medications listed on facility MAR from 12/1/16 through 12/14/16 matched physician order sheet dated 10/15/16 through 11/14/16 signed by medical care provider on 11/23/16. The record lacked documentation the medical care provider was contacted to clarify discrepancies between medications administered by outside agency on 11/30/16 and the medications listed on the physician order sheet signed on 11/23/16. For resident #1220, the licensed nurse failed to ensure medications were administered in accordance with professional standards of practice when the licensed nurse failed to seek clarification on discrepancies in medications administered by outside agency and medication orders in resident ' s facility record. Record review for resident #1219, admitted 7/10/14 documented diagnoses of bilateral knee osteoarthritis, neuropathy, vitamin D deficiency,	S3026		

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S3026	Continued From page 9 basal cell carcinoma, GERD (gastrointestinal reflux), chronic pain, hypertension, type II diabetes and hypothyroidism. FCS dated 10/9/16 documented resident required assistance with medication NSA/HCSP dated 10/26/16 documented outside agency provided medications and diabetic care; NSA/HCSP dated 12/6/16 documented facility staff to assist with medication as prescribed by the physician. Nurse ' s notes written on 12/6/16 at 8:51 a.m. documented 11/17/16 at 8:45 a.m. " . . .Self-management assessment completed with resident. Resident was able to name what medications he/she was receiving and why the medication was prescribed. Resident was not able to open pill bottles without assistance. Resident reported not being able to read labels on medication bottle or being able to turn dial on insulin pen to self-administer insulin. Resident was able to perform return demonstration on how to administer insulin. Resident is currently receiving services through outside agency. Resident will be on facility medication program beginning 12/1/2016. " Comparison of list of medication administered by the outside agency on 11/30/16 and 12/1/16-12/14/16 MAR for resident #1219 revealed the following discrepancies: Medications identified as administered by outside agency on 11/30/16 that were not listed as administered by facility staff on 12/1/16 through 12/14/16 MAR: - Ranitidine 150 mg (for GERD) 75 mg daily - -oxycontin 5 mg (for pain) 1 tablet daily	S3026		

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S3026	Continued From page 10 - Tylenol 500 mg (for pain) 1 tablet daily Medications identified as administered by outside agency on 11/30/16 with different dose listed as administered by facility staff on 12/1/16 through 12/14/16 MAR: - Aspirin 325 mg (analgesic) 1 tablet daily listed on facility MAR as Aspirin 81 mg daily -Humalog 100units/ml (insulin) per sliding scale before meals below 70 = call doctor; 141-200 = 8 units; 201-300 = 20 units; over 300 = call doctor listed on facility MAR as below 70 = call doctor; 121-140 2 units, 151-200 = 4 units; 201-250= 8 units; 301-350= 14 units over 350 call doctor. NOTE: physician order sheet dated 10/15/16-11/14/16 signed by medical care provider 11/15/16 documents sliding scale documented by outside agency - Lantus (insulin) 15 units every morning listed on facility MAR as Lantus 15 units twice daily. NOTE: physician order sheet dated 10/15/16-11/14/16 signed by medical care provider 11/15/16 documents Lantus 30 units every morning with a 2nd order for lantus 20 units with no time specified. - gabapentin 100 mg capsule (for neuropathy) 300 mg three times a day listed on facility MAR as gabapentin 400 mg capsule 1 by mouth twice a day - Furosemide 40 mg (diuretic) twice a day morning and noon listed on facility MAR as 1 time daily at 8 am - Losartan Potassium 100 mg (for high blood pressure) 1 time per day listed on facility MAR as Losartan Potassium 50 mg 1 tablet per day Medications listed on facility MAR as	S3026		

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administered from 12/1/16 through 12/14/16 that were not administered by outside agency on 11/30/16:
- Omeprazole 20 mg (for GERD) 1 capsule daily
- Tramadol HCL 50 mg (for pain) every 4-6 hours as needed

Medications listed on facility MAR from 12/1/16 through 12/14/16 matched physician order sheet dated 10/15/16 through 11/14/16 signed by medical care provider on 11/15/16 except the insulin orders noted above. The record lacked documentation the medical care provider was contacted to clarify discrepancies between medications administered by outside agency on 11/30/16 and the medications listed on the physician order sheet signed on 11/15/16. Insulin order was not clarified until 12/12/16.

For resident #1219, the licensed nurse failed to ensure medications were administered in accordance with professional standards of practice when the licensed nurse failed to seek clarification on discrepancies in medications administered by outside agency and medication orders in resident ' s facility record.

Record review for resident #1221 recorded admission date of 9/18/16 with diagnoses of: Cerebral vascular accident, trigeminal neuralgia, depression and hypothyroidism.

FCS dated 12/1/16 recorded resident resident required assistance with management of medications and treatments.

NSA/HCSP dated 12/1/16 recorded facility staff will assist with medications as prescribed by the physician, will administer all medications to

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resident, will administer nebulizer treatments to resident and will order resident ' s medications from the pharmacy.

Nurses notes dated 11/29/16 at 7:50pm recorded self- medication assessment completed. Resident could not verbalize what medication he//she was taking or what he/she was taking the medication for. Resident is currently receiving service through [outside agency] Resident will be on [facility] medication program upon return to [facility].

Nurses notes dated 11/2/16 at 11:41am recorded resident was admitted to the hospital.

Nurses notes dated 12/1/12 at 11:30am recorded resident returned the facility from a nursing facility.
Medication review report from the nursing facility signed by physician on 11/28/16, recorded the following medications that were not recorded on the 12/1/16 through 12/14/16 MAR (medication administration record)
-Allegra allergy tablet 60 mg (milligrams) by mouth every 24 hours as needed for allergic rhinitis

Medications listed on facility MAR as administered from 12/1/16 to 12/2/16 not listed on 11/28/16 medication review report from the nursing facility:

-Lyrica 150mg (for nerve pain), Give 150mg by mouth 2 times a day.

Comparison of list of medications administered by outside agency prior to hospitalization on 11/2/16 and 12/1/16 through 12/14/16 MAR for resident #1221 revealed the following

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S3026	Continued From page 13 discrepancies: Medications identified as administered by outside agency prior to hospitalization on 11/2/16 that were not listed as administered by facility on 12/1/16-12/14/16 MAR: -Allegra allergy 12 hour, non-drowsy 60 mg (milligram) tablet (antihistamine medication for allergies) oral (by mouth) PRN (as needed) - Lasix 20 mg tablet oral one time daily. (Diuretic medication) - Potassium Chloride 10 meq (millequivilents) tablet, extended release, Oral, one time daily. (mineral supplement) - Hydrocortisone pramoxine 2.5-1% (percent) cream with applicator, topical, three times daily to affected areas. (medication for hemorrhoids) - Hydrocodone 5mg/ acetaminophen 325mg tablet, ½ to 1 tablet, oral, PRN, every six hours. (narcotic pain medication). Medications identified as administered by outside agency prior to hospitalization on 11/2/16 with a different dose listed as administered by facility staff on 12/1/16 through 12/14/16 MAR: - Lyrica 50mg capsule, oral, two times daily AM (morning) and HS (at hour of sleep) (medication for seizures) documented as 150mg by mouth 2 times daily by facility. MAR dated 12/1/16 though 12/14/16 included order for DuoNeb solution 0.5-2.5 mg/3ml (milliliters) 1 vial inhale orally 3 times a day for shortness of breath, document lung sound in NN (nurses notes). All doses for 12/1/16 through 12/7/16 were circled as not given and noted equipment was not available. The record lacked documentation the medical care provider was notified the medication was not given and failed to document assessment of lung sounds.	S3026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089030	A. BUILDING: _____ B. WING _____	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3026	Continued From page 14 For resident #1221, the licensed nurse failed to ensure medications and treatments were administered in accordance with professional standards of practice when the licensed nurse failed to seek clarification on discrepancies in medications and treatments administered by outside agency and medications as ordered by the physician after a hospitalization. The licensed nurse also failed to administer medications as ordered by the physician after readmission following a hospital stay.	S3026		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility 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 facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by:	S3200		

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S3200	Continued From page 15 KAR 26-42-205(d) The facility reported a census of 30 residents. The sample included 6 residents and 2 closed chart review residents. Based on record review and interview, the operator failed to ensure all medications and treatments were administered in accordance with professional standards of practice as evidenced by review of resident records for residents (#1218 and #1219) who received as needed (PRN) medications administered by the certified staff without seeking instructions from the licensed nurse. Findings included: - Record review for resident #1218 recorded admission date of 8/22/14 with diagnoses of: gastroesophogeal reflux disease (GERD), osteoporosis, atrial fibrillation, congestive heart failure, coronary artery disease, hypertension, chronic obstructive pulmonary disease anxiety and depression. Functional Capacity Screen (FCS) dated 12/5/16 recorded resident required assistance with management of medications. Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 12/5/16 recorded staff to administer all medications. Medication administration record for 12/1/16 through 12/14/16 recorded Oxycodone hydrochloride 5 mg (milligrams) (a narcotic pain medication) 1 tablet by mouth every 6 hours as needed. Initialed as given by certified staff #X on 12/6/16 and by certified staff #W on 12/9/16 with notation of reason as " pain " . Nurses notes lacked documentation of discussion of resident	S3200		

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S3200	Continued From page 16 condition with certified staff and lacked follow up assessment related to the resident ' s complaint of pain. Interview on 12/20/16 with certified staff # X confirmed he/she administered the controlled narcotic on 12/6/16. He/she stated he/she notified a nurse after administering the medication and did not know if the nurse assessed the resident. The certified staff did not seek instruction prior to administering a PRN narcotic medication to a resident. Record review for resident #1219 recorded admission date of 7/10/14 with diagnoses of: bilateral knee osteoarthritis, neuropathy, vitamin D deficiency, basal cell cancer of the nose, GERD, diabetes type 2chronic pain, dry eye, hypertension, and hypothyroidism. FCS dated 12/6/16 recorded resident required assistance with management of medications. NSA/HCSP dated12/6/16 recorded staff to assist with medications as ordered by the physician. Medication administration record for 12/1/16 through 12/14/16 recorded hydrocodone/acetaminophen 5mg/325mg (a narcotic pain medication) 1 tablet by mouth every 6 hours as needed for pain. Initialed as given by staff 17 times with notation of reason as " pain " . Nurses notes lacked documentation of discussion of resident condition with certified staff and lacked follow up assessment related to the resident ' s ongoing complaint of pain.	S3200		

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S3200	Continued From page 17 Interview on 12/20/16 at 3:15pm with certified staff #V confirmed he/she administered the controlled narcotic medication 8 times. He /she confirmed he/she did not notify the nurse until after medication was administered. He/she stated " Usually I notify them (the nurse) within 30 minutes (after), it depends when I can get ahold of them, they are usually next door. " He/she confirmed pain levels are not recorded. Interview on 12/20/16 at 5:00pm with licensed staff # Y confirmed certified staff does not seek instructions from a nurse prior to administration of PRN medications. Facility policy on PRN medications lacked instruction for medication aides to seek nurse instruction prior to administering PRN medications. For all residents with facility managed medications, the operator failed to ensure all medications and treatments were administered in accordance with professional standards of practice as evidenced by review of resident records for residents (#1218 and #1219)) who receive as needed (PRN) medications administered by the certified staff without instructions from the licensed nurse.	S3200		