STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006006	A. BUILDING: _____ B. WING _____	12/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE MEMORY CARE OF FORT SCOTT	822 S HORTON STREET FORT SCOTT, KS 66701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named home plus facility conducted on 12-12-16 and 12-13-16.	S 000		
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 6 residents. The sample included 3 residents and one closed record review. Based on record review and interview for 2 (#122, #123) of 3 sampled residents, the operator failed to ensure all medications and biologicals were administered to that resident in accordance with professional standards of practice.	S5300		

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

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S5300	Continued From page 1 Findings included: - Record review for resident #122 revealed admission on 10-22-16 with diagnoses Dementia, Coronary Artery Disease, Hypertension, Hyperlipidemia, Degenerative Disc Disease Lumbar and Sleep Apnea. The Functional Capacity Screen dated 10-22-16 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement dated 10-22-16 recorded services for "Facility management of medications." Review of Medication Administration Record (MAR) for December 2016 revealed the following: Celecoxib 200 mg (milligrams) take one capsule by mouth once daily as needed for pain. On 12-1-16, 12-3-16, 12-4-16, 12-7-16 and 12-12-16 the medication was documented as administered by mouth by a certified medication aide for "complaint of hand pain". The record lacked documentation of time of administration and staff follow up for effectiveness of medication. The record also lacked documentation of consultation with the nurse prior to administration and assessment or evaluation of resident's hand pain by a licensed nurse. - Record review for resident #123 revealed admission on 4-27-16 with diagnoses Alzheimer's Dementia and Delusional Disorder. The Functional Capacity Screen dated 11-2-16 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement dated 11-2-16 recorded services for "Facility management of medications: staff nurse or certified medication aide to administer resident's medications as ordered."	S5300		

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S5300	Continued From page 2 Review of Medication Administration Record (MAR) for December 2016 revealed the following: Ultram 50 mg 1 tablet by mouth every 8 hours as needed for pain. On 12-4-16 the medication was documented as administered twice by mouth for "pain in back" and "complaint of pain". Both entries lacked documentation of time of administration and follow up for effectiveness of medication. On 12-6-16 and 12-7-16 the medication was documented as administered. Both entries lacked documentation of follow up for effectiveness of medication. The record also lacked documentation of consultation with the nurse prior to administration and assessment or evaluation of resident's pain by a licensed nurse. Interview on 12-13-16 at 9:30 am with Licensed Staff B stated when he/she is at the facility, certified staff ask him/her about giving "as needed" medications and if he/she is not at facility, they will call and ask. Confirmed the above records lacked documentation of time of administration and/or staff follow up for effectiveness of the medication. Further confirmed the record lacked documentation of assessment or evaluation by the nurse prior to giving instruction to certified staff to administer the "as needed" medication. For residents #122 and #123, the operator failed to ensure all medications and biologicals were administered in accordance with professional standards of practice when certified medication aides failed to document consultation with a licensed nurse prior to administration of as needed medications; failed to document of times of administration and failed to document follow up of effectiveness of medications.	S5300		

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S5320	Continued From page 3	S5320		
S5320 SS=F	26-42-205 (k) Medication Clinical Records (k) Clinical record. The administrator or operator, or the designee, shall ensure that the clinical record of each resident for whom the home manages the resident ' s medication or prefills medication containers or syringes contains the following documentation: (1) A medical care provider ' s order for each medication; (2) the name of the pharmacy provider of the resident ' s choice; (3) any known medication allergies; and (4) the date and the 12-hour or 24-hour clock time any medication is administered to the resident. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(k)(4) The facility reported a census of 6 residents. The sample included 3 residents and one closed record review. For all residents, the operator or the designee failed to ensure that the clinical record of each resident for whom the home manages the resident's medication contains documentation of the date and the 12-hour or 24-hour clock time any medication is administered to the resident based on record review and interview for 3 (#121, #122, #123) of 3 sampled residents and affecting all residents. Findings included: - Record review for resident #121 revealed	S5320		

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S5320	Continued From page 4 admission on 3-28-16 with diagnoses Dementia and History of Cardiovascular Accident and Transient Ischemic Attacks. The Functional Capacity Screen dated 9-13-16 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement dated 9-13-16 recorded services for "Facility management of medications: staff nurse or certified medication aide to administer resident's medications as ordered." Review of Medication Administration Record for December 2016 revealed the following: Docusate 100 mg (milligrams) cap (capsule) for stool softener - documented as administered in AM Folic Acid 1 mg (supplement) - documented as administered in AM Melatonin 3 mg (for insomnia) - documented as administered at HS (hour of sleep) Amlodipine 5 mg (for hypertension) - documented as administered in AM Citalopram 15 mg (for depression) - documented as administered in AM Divalproex 125 mcg (micrograms) (for dementia with behaviors) - documented as administered AM and HS Rivastigmine patch 4.6 mg/24 hours - documented as applied in AM Dronabinol 2.5 mg cap (for appetite) - documented as administered in AM and PM Vitamin D 50,000 units weekly on Thursdays - documented as administered in AM The record lacked documentation of the 12-hour or 24-hour clock time when the medication was administered. - Record review for resident #122 revealed admission on 10-22-16 with diagnoses Dementia,	S5320		

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S5320	Continued From page 5 Coronary Artery Disease, Hypertension, Hyperlipidemia, Degenerative Disc Disease Lumbar and Sleep Apnea. The Functional Capacity Screen dated 10-22-16 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement dated 10-22-16 recorded services for "Facility management of medications." Review of Medication Administration Record for December 2016 revealed the following: Aspirin 81 mg (milligrams) (for blood thinner) - documented as administered in AM Benazepril 20 mg (for Hypertension) - documented as administered in AM Centrum Silver multivitamin (supplement) - documented as administered in AM Hydrochlorothiazide 25 mg (diuretic) - documented as administered in AM Omega 3 fatty acids 2000 mg (supplement) - documented as administered in AM Omperazole 20 mg (for gastric reflux) - documented as administered in AM Sertraline 100 mg (for depression) - documented as administered in AM Divalproex 125 mg (for dementia with behaviors) - documented as administered at HS (hour of sleep) - Record review for resident #123 revealed admission on 4-27-16 with diagnoses Alzheimer's Dementia and Delusional Disorder. The Functional Capacity Screen dated 11-2-16 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement dated 11-2-16 recorded services for "Facility management of medications: staff nurse or certified medication aide to	S5320		

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S5320	Continued From page 6 administer resident's medications as ordered." Review of Medication Administration Record for December 2016 revealed the following: Divalproex 250 mg(for mania) - documented as administered in AM and HS (hour of sleep) Nexium 40 mg (for stomach ulcer) - documented as administered in AM Furosemide 20 mg (diuretic) - documented as administered in AM Haloperidol 1 mg (for dementia with behaviors) - documented as administered in AM Haloperidol 2 mg - documented as administered at HS Levothyroxin 50 mcg (micrograms) (for hypothyroidism) - documented as administered in AM Metoprolol 50 mg (for hypertension) - documented as administered in AM Interview on 12-12-16 at 3:05 pm with Licensed Staff B confirmed the Medication Administration Records lacked documentation of the 12-hour or 24-hour clock time when the medications were given. Stated the administration times are not scheduled because residents get up and eat breakfast at different times. The time of the AM dose can affect the time the PM dose is given so, "we don't assign a specific time to administer." Confirmed the times of administration were not documented elsewhere on the MAR or in notes. For all residents, the operator or the designee failed to ensure that the clinical record contained documentation of the date and the 12-hour or 24-hour clock time medications were administered to the residents based on record review and interview for 3 (#121, #122, #123) of 3 sampled residents and affecting all residents for whom the home manages medications.	S5320		

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S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(a) The facility reported a census of 6 residents. The sample included 3 residents and one closed record review. Based on observation and interview for all residents, the operator failed to ensure the facility was maintained to protect the health and safety of the residents when chemicals were unsecured in a kitchen cabinet underneath the sink. Findings included: - Observation on 12-12-16 at 11:30 am during entrance tour with Administrative Staff A revealed an open floor plan for the dining room, living room and kitchen area. Observed the following in the cabinet underneath the kitchen sink: 1 bottle of Cerama Brite Stove Top Cleaner; 2 can Stainless Steel Polish; 1 repackaged spray bottle of Proforce Sanitizer for kitchen and dining room; boxes of Cascade laundry detergent for dishwasher and 1 bottle of Goo Gone. The roster identified 6 of 6 home plus residents	S5335		

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S5335	Continued From page 8 with impaired cognition. Observation on 12-13-16 around 9:10 am revealed a resident ambulating with roller walker in the kitchen with no staff in attendance. Interview on 12-12-16 at 11:30 am with Administrative Staff A confirmed the chemicals were unsecured. Stated the magnet lock had broken. For all residents, the operator failed to ensure the facility was maintained to protect the health and safety of the residents when chemicals were unsecured in a kitchen cabinet underneath the sink.	S5335		