

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/29/2016
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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 are the result of a Licensure Resurvey at the above named Assisted Living Facility in Leawood, Kansas on 11/15/16, 11/16/16, 11/17/16, 11/28/16, and 11/29/16. Complaint #88918 also investigated.	S 000		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility 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 26-41-204(a) The census equalled 28 the sample included three Residents. Based on observation, interview, and reviews of record, for two of six sampled (#189 and 185), the Operator failed to ensure a Licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each Resident. Findings included: - Review of record revealed #189 admitted to facility 3/09/16 with diagnoses of Dementia, Hypertension, Gastroesophageal reflux disease, Anxiety, Traumatic brain injury, Low back pain, and Osteoporosis.	S3155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3155	Continued From page 1 The current 10/05/16 FCS (functional capacity screen) assessed #189 in need of medication and treatment management (3) unable to perform. The current 10/05/16 NSA (negotiated service agreement) documented #189 to receive medication management by facility. By interview, #I not aware of need to separate the antibiotic and probiotic medications... set up on the MAR that way... By interview on 11/17/16 at 11:42am, CMA #I stated we use liberalized medication times... the electronic system will alert us if PRN medication "too soon" in conjunction with last administered dose... does not alert us to timing of routine scheduled medications... system relies on the times listed at left of screen for person administering medications to heed and determine if too soon to administer next dose. Interview of Resident Care Coordinator #G and Regional Nurse #K on 11/16/16 at 4:00pm, and on 11/17/16 at 1:01pm confirmed the facility medication policies and procedures lacked specific instructions related to administration times that became closer than recommended time frames due to the liberalized medication time allowances. The Operator failed to ensure all medications administered to #189 in accordance with professional standards of practice. The current functional capacity screen (FCS) of 9/29/16 assessed #189 in need of physical	S3155		

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S3155	Continued From page 2 assistance with bathing, dressing, toileting, transfers, and mobility; independent with eating; unable to perform medication and treatment management; with incontinence of bladder; with memory recall and decision making impairment; understands and understood; with falls/unsteadiness, used wheel chair. The current NSA of 10/13/16 documented staff to provide services to meet these identified needs. Clinical Notes documented: 11/14/16 - 10:39am - evaluation by PT (physical therapy)... request by Resident to use gait belt/seat belt to avoid additional falls from wheelchair as occurred on 11/10/16... family member stated will buy seat belt for wheelchair if that would be allowed 10/10/16 - 12:39 - order for speech therapy sent to physician... 10/05/16 - 2:38pm - arrived back at facility... able to stand and pivot... assistance with toileting... also has a new bed with perimeter mattress to prevent rolling out of bed again... 8/28/16 - 5:23pm - to hospital... rolled out of bed... admitted with hip fracture... The NSA of 10/13/16 lacked the interventions to address falls (seat belt, perimeter mattress) and lacked the addition of ST (speech therapy) for swallowing difficulties. By interview on 11/17/16 at 10:25am, Resident #189 reported fall prevention as a "seat belt." By observation, the seat belt not in place... assisted Resident in locating seat belt caught and intertwined under wheelchair seat and frame... #189 clicked seat belt ends together at that time and stated it served to remind him/her not to stand without assistance.	S3155		

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S3155	Continued From page 3 By interview on 11/17/16 at 11:25am, certified staff #I stated #189 is total care... fell out of wheelchair recently in dining room by pulling self along with post... has a seat belt... actually I am just noticing that... not sure of when that started... I am assuming we apply it... we remind to push call light also to prevent falls... By interview on 11/17/16 at 11:55am, certified staff #J stated has a matt on floor next to bed for falls... has a call pendant... knows to push pendant... not aware of any seat belt.. By interview on 11/17/16 at 12:41pm, Resident Care Coordinator #G confirmed the perimeter mattress, the seat belt, and the Speech therapy services all active but not on the current NSA. The Operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of #189 in regard to the speech therapy and fall prevention. - Review of record revealed #185 admitted to facility 7/25/16 with diagnoses of Dementia, Hypertension, Gastroesophageal reflux disease, Anxiety, Chronic pain, Lumbago with sciatica, Dysphasia, and History of falling. The current 8/17/16 FCS (functional capacity screen) assessed #185 in need of physical assistance with bathing, dressing, toileting; in need of supervision with transfers and mobility; unable to perform medication and treatment management; with bladder incontinence; with short term and long term memory difficulty, with memory recall and decision making impairment;	S3155		

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S3155	Continued From page 4 with falls/unsteadiness, and used walker or wheelchair. The current 8/17/16 NSA (negotiated service agreement) documented #185 to receive services to address these identified needs, including every two hour toileting and the use of call pendant for assistance. Observation and interview on 11/17/16 at 9:45am revealed #185 laying crosswise on bed with blankets in disarray... stated he/she was not in need of any help... if he/she needed help would push call button on wrist, but it had been missing since "day before yesterday... I will get a new one when I go out shopping"... By interview on 11/17/16 at 11:30am, certified staff #I stated for fall prevention #185 is to push call pendant... likes to sleep in, in the mornings... we help him/her to the bathroom... we are looking for wrist band call pendant now... don't know when it came off... according to certified staff #J had it yesterday By interview on 11/17/16 at 1:01pm, Resident Care Coordinator #G confirmed the wrist pendant call system noted on the NSA not in use... confirmed he/she did not know when it came up missing... stated staff should have noted that and reported to me immediately... needs to be replaced immediately due to #185 is to call for assistance... The Operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of #185 in regard to the toileting assistance and fall prevention.	S3155		

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S3200	Continued From page 5	S3200		
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: KAR 26-41-205(d)(1-2) The facility census equalled 28, the sample included three Residents. The facility identified 24 Residents as receiving medication management. Based on interviews and reviews of record, for three of three sampled (#189, #187, and, #185), the Operator failed to ensure all medications administered in accordance with medical provider's written orders and in accordance with professional standards. Findings included:	S3200		

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S3200	Continued From page 6 - Review of record revealed #189 admitted to facility 3/09/16 with diagnoses of Dementia, Hypertension, Gastroesophageal reflux disease, Anxiety, Traumatic brain injury, Low back pain, and Osteoporosis. The current 10/05/16 FCS (functional capacity screen) assessed #189 in need of medication and treatment management (3) unable to perform. The current 10/05/16 NSA (negotiated service agreement) documented #189 to receive medication management by facility. Review of the 11/2016 MAR (medication administration record) revealed #189 received medications administered by staff. Documentation of administration failed to meet professional standards of practice. MAR contained order for Robaxin (muscle relaxant) 500mg (milligrams) give 1000mg (two 500mg tabs) four times daily. MAR documentation revealed four doses administered at three times per day on 11/04/16, 11/09/16 and 11/11/16: 11/04/16 - 7:31, 11:29, 20:22, and 20:22 11/09/16 - 7:22, 11:14, 20:38, and 20:38 11/11/16 - 8:12, 12:32, 20:27, and 20:27 MAR documentation revealed doses of this "four times daily" (or roughly six hours apart) medication Robaxin administered as soon as 2 1/2 hours apart: 11/01/16 - 7:08, 12:14, 16:27, 20:03 - 3 1/2 hours apart 11/07/16 - 7:36, 10:23, 15:30, 20:45 - 3 hours	S3200		

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S3200	Continued From page 7 apart 11/10/16 - 8:35, 11:57, 15:55, 217 - 3 1/2 hours apart 11/12/16 - 7:45, 10:51, 16:50, 20:32 - 3 hours and 3 1/2 hours apart 11/14/16 - 7:26, 9:55, 15:34, 20:31 - 2 1/2 hours apart 11/16/16 - 7:29, 10:27, 16:26, 20:31 - 3 hours apart MAR contained order for Cipro (antibiotic) 250mg twice daily, and Lactobacillus acidophilus (probiotic) one tablet three times daily. Review of administration timing at consumerlab.com suggested antibiotics and probiotics at least two hours apart to decrease possibility of antibiotic destroying the probiotic organisms. MAR documentation revealed these medications administered at same time on: 11/11/16 (12:32 and 20:27) 11/12/16 (10:51) 11/13/16 (11:10) 11/14/16 (9:55) 11/15/16 (11:02) 11/16/16 (10:27) By observation on 11/17/16, observed CMA (certified medication aide) #I administer both medications to #189 at 11:22. By interview, #I not aware of need to separate the antibiotic and probiotic medications... set up on the MAR that way... By interview on 11/17/16 at 11:42am, CMA #I stated we use liberalized medication times... the electronic system will alert us if PRN medication "too soon" in conjunction with last administered dose... does not alert us to timing of routine scheduled medications... system relies on the times listed at left of screen for person	S3200		

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S3200	Continued From page 8 administering medications to heed and determine if too soon to administer next dose. Review of facility Policy and Procedure for Medication Management failed to address the decision making process for medications administered closer together than the recommended time frames. Interview of Resident Care Coordinator #G and Regional Nurse #K on 11/16/16 at 4:00pm, and on 11/17/16 at 1:01pm confirmed the facility medication policies and procedures lacked specific instructions related to administration times that became closer than recommended time frames due to the liberalized medication time allowances. The Operator failed to ensure all medications administered to #189 in accordance with professional standards of practice. - Review of record revealed #185 admitted to facility 7/25/16 with diagnoses of Dementia, Hypertension, Gastroesophageal reflux disease, Anxiety, Chronic pain, Lumbago with sciatica, Dysphasia, and History of falling. The current 8/17/16 FCS (functional capacity screen) assessed #185 in need of medication and treatment management (3) unable to perform. The current 8/17/16 NSA (negotiated service agreement) documented #185 to receive medication management by facility. Review of the 11/2016 MAR (medication administration record) revealed #189 received	S3200		

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S3200	Continued From page 9 medications administered by staff. Documentation of administration failed to meet professional standards of practice. MAR contained order for Levothyroxine 25 micrograms daily. According to MayoClinic.org, this medication should be taken on an empty stomach with full glass of water 30 to 60 minutes prior to breakfast. MAR documentation revealed Levothyroxine doses administered at the same time as all other am medications and not on empty stomach, 1/2 hour prior to other medications or breakfast. (Other medications included: Aspirin to thin blood, Colace to soften stools, Miralax as laxative, Reglan for stomach motility, Fluoxetine an antidepressant). MAR contained orders for Sucralfate (ulcer treatment), Reglan (stomach motility), and Levsin (anti spasmodic). According to MayoClinic.org, these medications also to be taken 30 to 60 minutes prior to meals and at bedtime. According to the MAR, these medications administered simultaneously with other medications and not on empty stomach. The medical record lacked any notes by physician or pharmacist to proceed with administration against recommended guidelines. MAR contained order for Reglan and Sucralfate four times daily. MAR documentation revealed four doses administered at three times per day on 11/02/16, 11/04/16, 11/09/16, 11/10/16, 11/11/16, and 11/12/16: 11/02/16 - 9:03, 9:03, 15:35, 19:38 11/04/16 - 8:35, 9:51, 20:07, 20:07 11/09/16 - 8:04, 11:12, 20:21, 20:21 11/10/16 - 9:30, 9:30, 16:25, 20:14 11/11/16 - 8:34, 12:34, 20:16, 20:16	S3200			

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S3200	Continued From page 10 11/12/16 - 10:46, 10:46, 16:05, 20:20 The Operator failed to ensure all medications administered to #187 in accordance with professional standards of practice. - Review of record revealed #187 admitted to facility 4/01/08 with diagnoses of Dementia, Antiphospholipid syndrome, Aphasia, Anxiety, Depression, Gout, Atrial fibrillation, Difficulty in walking, and Ortho hypotension. The current 12/14/15 FCS (functional capacity screen) assessed #187 in need of medication and treatment management (3) unable to perform. The current 12/10/15 NSA (negotiated service agreement) documented #187 to receive medication management by facility. Review of the 11/2016 MAR (medication administration record) revealed #187 received medications administered by staff. Documentation of administration failed to meet professional standards of practice. MAR contained order for Quetiapine fumarate (Seroquel an antipsychotic) three times daily. MAR documentation revealed three doses administered at two times per day on 11/04/16, 11/11/16, and 11/16/16: 11/04/16 - 8:31, 19:40, 19:40 11/11/16 - 8:54, 20:04, 20:04 11/16/16 - 6:59, 19:49, 19:49 The Operator failed to ensure all medications administered to #187 in accordance with	S3200		

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S3200	Continued From page 11 professional standards of practice.	S3200			