STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	09/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

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S 000	INITIAL COMMENTS The following citations are the result of a Licensure Resurvey at the above named Assisted Living Facility in Lyons, Kansas on 8/31/16 and 9/01/16. Complaint #104189 also investigated.	S 000		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	S3028		

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

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S3028	Continued From page 1 KAR 26-41-101(f)(3)(B)(C)(D)(E)(F) The census equalled 16 the sample included three Residents. Based on interviews and reviews of records, for one non sampled (#170) with allegations of abuse, the Operator failed to: Report potential abuse to the department within 24 hours, and, Thoroughly investigate allegations of potential abuse. Findings included: - Record review revealed #170 admitted to facility 5/17/14 with diagnoses of Alzheimer's. 02/16/16 functional capacity screen (FCS) assessed #170 in need of physical assistance (2) with bathing and dressing; unable to perform (3) toileting, medication and treatment management; in need of supervision (1) with eating; independent (0) with transfers and mobility; incontinent (4) of bladder; with (4) short term memory, long term memory, memory recall, and decision making cognitive impairments; impaired communication (2 - 2) sometimes understands and sometimes understood; with impaired vision; with socially inappropriate behavior and impaired decision making. 02/16/16 Negotiated service agreement (NSA) documented facility staff to provide care and services to meet these identified needs. By confidential interview, an individual reported an incident in May 2016, alleging CMA (certified medication aide) #F "hit" Resident #170. The individual stated this allegation reported to the Operator of the facility after CMA #F left employment.	S3028		

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S3028	Continued From page 2 By interview on 8/31/16 at 1:10pm, Operator/LPN (licensed practical nurse) #A stated CMA #F gave notice to leave in May... I believe 5/12/16, and did not work out his/her notice... I received an allegation of abuse by CMA #F towards Resident #170 on 5/24/16... CMA #B reported that Resident #187 observed the "hitting." Operator/LPN #A stated I completed an "Incident Investigation Report... I attempted to obtain a statement from Resident #187, who responded "I don't know what your talking about"... he/she stated had no knowledge of the incident. Operator/LPN #A stated Resident #170 was unable to provide information about the alleged abuse. Operator/LPN #A confirmed I did not obtain any other statements (other alert Residents, dietary staff, etc.)... I did not know I was to report that to the hotline since I didn't confirm abuse... By review of record, the Resident Progress Notes of April and May 2016 for #170 lacked any documentation of the allegation and lacked a physical assessment of #170. The Operator failed to report potential abuse of #170 to the department within 24 hours, and failed to thoroughly investigate allegations of potential abuse.	S3028		
S3200 SS=D	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	S3200		

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S3200	Continued From page 3 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: 26-41-205(d)(1-2) The census equalled 16 the sample included three Residents. The facility identified 13 Residents with facility managed medications. Based on observation, interview, and review of record, for one of three sampled Residents with medication management (#185), the Operator failed to ensure all medications administered in accordance with a medical care provider's written order and professional standards of practice. Findings included: - Review of record revealed #185 admitted to facility 6/08/16 with diagnoses of Diabetes, Chronic obstructive pulmonary disease, and Cognitive decline. The current 6/08/16 functional capacity screen (FCS) assessed #185 unable to perform (3) medication and treatment management.	S3200		

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S3200	Continued From page 4 The 6/08/16 negotiated service agreement (NSA) documented facility staff to provide assistance with medication administration and treatment management. Comparison of the current August 2016 MAR (medication administration record) with signed written medical care provider orders revealed the following discrepancy: The MAR contained an order for "Metformin" (glucophage) (diabetic medication) 500mg (milligrams) BID (twice daily). The 6/08/16 signed order for this medication stated "Metformin 250mg BID. By observation on 8/31/16 at 6:40pm, in the medication storage room of facility, the current supply of medication was 500mg tablets, being administered BID. By review, the MAR's of June and July 2016 also recorded 500mg. By interview on 8/31/16 at 6:40pm, the Facility Nurse #C confirmed the original order of 250mg BID transcribed on the June MAR and called to the pharmacy in error... #C added however, the medication list had been sent to the physician 7/15/16 attached to pages of glucometer readings for 6/08/16 to 7/15/16, and physician had provided written order "continue same meds." Facility Nurse #C confirmed the dosage 250mg vs 500mg BID should have been clarified at the time of admission. The Operator failed to ensure #185 received all medications in accordance with a medical care provider's written order and in accordance with professional standards of practice.	S3200		

Kansas Department on Aging

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