STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N052007	A. BUILDING: _____ B. WING _____	12/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN OAKS ASSISTED LIVING	657 EISENHOWER LANSING, KS 66043

(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 with complaint investigations 82778 and 86115 conducted at the above named assisted living facility on 11-30-15, 12-1-15, and 12-2-15.	S 000		
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) The facility reported a census of 26 residents. The sample included 3 residents. Based on record review and interview for 2 (#100, #300) of 3 sampled residents, the operator failed to ensure that all medications and biologicals are administered to the resident in accordance with a medical care provider's written order, professional	S3200		

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

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S3200	Continued From page 1	S3200		

standards of practice and each manufacturer's recommendations.

Findings included:

- Record review for resident #100 revealed admission on 11-21-15 with diagnoses Hypertension, Constipation and Iron Deficiency Anemia. The functional capacity screen dated 11-21-15 recorded resident unable to perform management of medications and treatments. The negotiated service agreement dated 11-21-15 recorded services for facility certified medication aides (CMAs) and licensed practical nurse (LPN) to manage and order all medications.

Review of physician's orders and medication administration record (MAR) for November 2-15 revealed the following discrepancies:
Physician's Orders dated 11-23-15 for Amitriptyline 10 mg (milligrams) take one tablet at bedtime. The MAR lacked documentation of the order for amitriptyline.
The MAR revealed documentation of administration of the following medication without a physician's written order: Guaifenisin 200 mg two times daily (16 doses) and Tums Ultra Maximum Strength antacid tablets one tablet every morning (8 doses).

Interview on 12-1-15 at 3:19 pm with licensed staff B confirmed the discrepancies between the physician's orders and the medication administration record; and that resident failed to receive a medication as ordered by the physician and received medications that were no longer to be given.

For resident #100, the operator failed to ensure

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S3200	Continued From page 2 that all medications were administered to the resident in accordance with a medical care provider's written order. - Record review for resident #300 revealed resident admitted on 7/8/15 with diagnoses of falls, abdominal pain unspecified, actinic keratosis, anemia, and long term anticoagulant use. The functional capacity screen dated 7/8/15 recorded resident required physical assistance with medications and treatments. The Negotiated Services Agreement (NSA) dated 11/10/15, recorded services for the facility to provide assistance with medications and treatments per physicians order. Medication administration record (MAR) for November 2015 revealed: Carafate suspension 100 mg/ml (milligrams/milliliter) give 10 ml, oral four times daily, starting 7/8/15 Diagnosis: anti-ulcer; scheduled to be administered at 12:00 pm, 3:00 pm, 6:00 pm and 9:00 pm. Record lacked documentation of administration of medication on 11/4/15 at 6:00 pm and 9:00 pm, and 11/12/15 at 6:00 pm and 9:00 pm. Further review of MAR revealed multiple times the Carafate was documented as given right before resident ate lunch (example: 11:52 am on 11-6-15) or right after lunch (examples: 1:04 pm on 11-5-15, 1:13 pm on 11-7-15 and 1:00 on 11-13-15). Manufacturer recommendation is for medication to be given on an empty stomach (1 hour before meals or two hours after meals). Facility meal times are 8:00 am, 12:00 pm and 5:00 pm per	S3200		

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S3200	Continued From page 3 posted notice. Interview with administrative staff #A at 5:00 pm on 11/30/15, confirmed the above meal times and observation revealed meals to be served on time. Interview with licensed staff B on 12-2-15 at 3:45 pm stated the resident " doesn ' t get up and eat at regular times and refuses medication. Will tell staff ' I don ' t want them right now ' " . Stated he/she was not aware that staff failed to document administration of medication on 11-4-15 and 11-12-15. Further confirmed the physician was not notified of resident ' s eating patterns or refusal of medication. For resident #300, the administrator failed to ensure that all medications are administered to the resident in accordance with a medical care provider's written order, and professional standards of practice.	S3200		
S3216 SS=E	26-41-205 (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 facility in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the 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	S3216		

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S3216	Continued From page 4 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 26-41-205(i) The facility reported a census of 26 residents. The sample included 3 residents. Based on observation and interview for 2 (#100, #300) of 3 sampled residents and 2 (#301, #302) non-sampled residents, the licensed nurse and medication aides failed to maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation. Findings included: - Observation of medication room cabinet on 12-1-15 around 11:30 am revealed the following: One large box labeled to contain " Medications and Over the Counter " (medications) for residents #300 and #302 (both resident's date of admission 7-8-15). The box contained 18 open bottles of over the counter medications; 5 tubes of topical over the counter medications and 4 bottles and/or tubes of prescription medications. 2 large plastic bags of medications for residents #100 and #301 (both resident's date of admission 11-21-15) contained 13 bottles and/or tubes of	S3216		

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S3216	Continued From page 5 over the counter medications and 18 containers of prescription inhaled and topical medications. Interview on 12-1-15 at 11:30 am with licensed staff B identified the large plastic bags of medications as belonging to residents #100 and #301. Stated the box of medications belonging to residents #301 and #302 had been in the medication room at least since around August 2015 when he/she started working. Stated residents #100, #300, #301, #302 medications were managed by the facility. Confirmed he/she failed to maintain a record of receipt of the medications. For residents #100, #300, #301, and #302, the the licensed nurse and medication aides failed to maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation.	S3216		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 26 residents. The sample included 3 residents. Based on record review and interview for 1 (#300) of 3	S3261		

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S3261	Continued From page 6	S3261		

sampled residents, the administrator failed to ensure documentation of all incidents, and indications of injury including date, time of occurrence, action taken and results of the action.

Findings included:

- Record review for resident #300 revealed admission date of 7/8/15 with diagnoses of falls, abdominal pain unspecified, actinic keratosis, anemia, and long term anticoagulant use.
The functional capacity screen (FCS) dated 7/8/15 recorded resident unable to perform bathing and dressing, requires physical assistance with toileting and transfers, uses a cane and wheelchair, and is at risk for falls/unsteadiness with impaired vision. Requires supervision for walking/mobility.
Negotiated service agreement (NSA) of 7/8/15 recorded facility will provide assistance with toileting every two hours during the day and offer encouragement to change brief during the night as needed. Will provide assistance with transfers and remind resident to use his pendant to call for assistance with transfers.
Review of clinical notes revealed resident experienced falls on 10-3-15 (early morning) and 10-9-15 (received report from family member that resident fell in the middle of the night).
Clinical notes dated 10-11-15 at 12:43 pm stated: "(resident) complained of slight pain to head, stated it hurts when he/she rests head against recliner. Lortab administered ...noted 4 staples in left scalp near crown of head ...received order for tetanus shot per emergency room physician. Wound care instructions are to change dressing twice daily after washing with warm water and soap. Blot dry and cover wound. Noted emergency room report to have hemoglobin

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S3261	Continued From page 7 rechecked." Signed by licensed staff B. The record lacked documentation of incident which caused the scalp laceration, documentation of being sent to the emergency room and condition upon return to the facility and further lacked documentation of assessment and follow up by a licensed nurse. Review of records revealed Emergency Room visit on 10/11/15 4:07 am, head injury with staple wound closure. Clinical notes of 10/11/15 failed to reveal any documentation of fall with head injury, transfer to emergency room, notification of family and physician and return from hospital. Facility policy for "Accidents and Occurrences" stated "The licensed nurse will ...Complete documentation of the occurrence and assessment of the resident in the nurse' notes of the resident's record; complete a physical assessment to include vital signs every shift for 72 hours following the occurrence; and document in the nurse' notes; and check the nurse' notes for three days to ensure follow-up documentation is completed. Interview of 12/1/15 at 1:30pm, licensed staff #B confirmed the record lacked documentation of an injury fall. The nurse further failed to follow the facility policy for documentation. For resident #300 operator failed to ensure documentation of injury including date, time of occurrence, action taken and results of the action when resident fell and sustained a head injury requiring transfer from the facility and medical treatment.	S3261		