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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a resurvey with complaint investigation 94530 conducted at the above named home plus facility on 12-3-15, 12-7-15, 12-8-15 and 12-9-15. Amended 2567 mailed to facility on 12/17/15 | S 000 | | |
| S5065 SS=J | 26-42-200 (a) Resident Criteria<br><br>(a) The administrator or operator of each home plus shall ensure the development and implementation of written admission, transfer, and discharge policies that protect the rights of each resident, pursuant to K.A.R. 26-39-102. In addition, the administrator or operator shall ensure that any resident who has one or more of the following conditions is not admitted or retained unless the negotiated service agreement includes services sufficient to meet the needs of the resident:<br>(1) Incontinence, if the resident cannot or will not participate in management of the problem;<br>(2) immobility, if the resident is totally dependent on another person ' s assistance to exit the building;<br>(3) any ongoing condition requiring two or more persons to physically assist the resident;<br>(4) any ongoing, skilled nursing intervention needed 24 hours a day; or<br>(5) any behavioral symptom that exceeds manageability.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-200(a)(5)<br><br>The facility reported a census of 8 residents and 2 day care residents. The sample included 3 residents and 1 focus review resident. Based on | S5065 | | |

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

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observation, record review and interview for 1 (#630) of 3 sampled residents, the operator failed to ensure that a resident with ongoing skilled nursing interventions needed 24 hours a day related to management of #630 ' s tracheostomy and portable ventilator, was not retained unless the negotiated service agreement (NSA) included services sufficient to meet the needs of the resident. The failure to provide 24 hour staff trained in care of a ventilator dependent resident and emergency procedures related to malfunction of the ventilator or displacement of the tracheostomy placed this resident in immediate jeopardy for harm, injury and death.

Findings included:

- Record review for resident #630 revealed admission on 6-26-15 with diagnoses that included Charcot-Marie-Tooth Disease, Quadriplegia and Osteomylitis of the heel.

The functional capacity screen (FCS) dated 6-26-15 recorded resident unable to perform bathing and walking/mobility; required physical assistance with dressing, toileting, transfer and management of medications and treatments; and independent with eating. Cognition: problems with decision-making. No problems with communication. Current problems/risks: falls/unsteadiness.

The negotiated service agreement/health care service plan (NSA/HCSP) dated 6-26-15 recorded the following services:
Staff assistance with bathing and dressing. Uses motorized wheelchair. " will need staff to assist with feeding and cutting up meats. " Nursing services to be provided: Medication Management, treatments, tracheostomy care,

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| S5065 | Continued From page 2<br>etc. "<br><br>The NSA/HCSP lacked interventions for management of tracheostomy and portable ventilator machine, services provided by the outside agency who monitored and serviced the ventilator, and emergency procedures for ventilator management for certified staff to follow.<br><br>Physician orders dated 9-3-15 stated, " Skilled nursing should change tracheostomy once a month, Suction at least once a day and as needed per resident ' s request. (outside agency) in charge of ventilator. Ventilator settings: Volume 600, Mode SIMV (Synchronized intermittent mandatory ventilation rate 12; Alarm settings ION 14; High 60; Pressure limit/support 10; PEEP (positive end-expiratory pressure) 4; I-time/peak flow 0.9. Oxygen at 2 liters as needed.<br><br>Nurses notes revealed daily documentation by licensed staff B for suctioning of resident and provision of tracheostomy care.<br><br>Nurses notes further documented:<br>11-20-15 (no time documented): " Nurse assisted resident with suctioning, large secretions, thick. Nurse requested that resident go out to hospital because there appears to be an infection setting in his/her system. Resident stated that he/she was not going out. " Signed by licensed staff B.<br><br>The record lacked documentation that the physician was notified of the change in secretions.<br><br>11-24-15 (no time documented) " Resident was sent out to hospital for infection. " Signed by | S5065 | | |

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| S5065 | Continued From page 3<br>licensed staff B.<br><br>Nurses notes further recorded resident #630 returned to facility on 11-30-15 after hospitalization for Pneumonia, Sepsis and pressure ulcers.)<br><br>Observations of resident #630 on 12-3-15 and 12-7-15 revealed resident sitting in electric wheelchair with gel cushion. Alert and oriented to person, place, time and situation. Limited use of both hands, unable to make fists. Required 2 staff to transfer from bed to wheelchair due to inability to stand or bear weight on legs. Portable ventilator hanging on back of wheelchair with white tubing going into a tracheostomy tube in throat.<br><br>Interview on 12-3-15 at 2:15 pm with resident #630 confirmed facility staff managed portable ventilator and the outside agency came monthly to check the ventilator and bring tubing.<br><br>Interviews on 12-3-15 and 12-7-15 with administrative staff A stated normal staffing pattern at facility included 2 staff on duty during the day, only one certified staff member scheduled to work the night shift. Routinely from 8:00 pm until 7:00 am, there was only one certified staff scheduled. Further confirmed that while a licensed practical nurse was available for unscheduled needs, the nurse did not work regularly scheduled hours at the facility and was not available during the day to come to the facility. Administrative staff A provided documentation from an outside agency, which monitored and serviced the portable ventilator, for staff training on use of the machine. The sign-in sheet contained documentation of all facility certified staff and licensed practical nurse (LPN) | S5065 | | |

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| S5065 | Continued From page 4<br>B. The sheet lacked documentation of training of the facility ' s RN (registered nurse) C.<br><br>Interview and observation on 12-3-15 at 3:20 pm with certified staff D stated he/she was trained by the outside agency that serviced the portable ventilator on how to charge and change the batteries, reset the alarms and change the tubing. Provided demonstration on how to change the batteries. Stated batteries usually last 3 hours. Stated if there was an emergency, he/she would call the nurse and call 911.<br><br>Interview on 12-3-15 at 3:50 pm with LPN B confirmed he/she comes to facility daily every morning to suction resident. Confirmed he/she lacked training for ventilators other than what the outside agency had provided. Stated the agency showed them " how to work the machine and connect the tubing. " Confirmed the " as needed " order to suction, that he/she would not always be available to come suction the resident; in an emergency if resident needed to be suctioned, no staff would be immediately available to suction. LPN B further confirmed he/she failed to consult with RN C regarding appropriateness of placement prior to approving resident ' s admission and further failed to consult with the RN C regarding a plan of care for the resident.<br><br>Interview on 12-9-15 at 11:50 am with representative from outside agency stated facility staff received an instruction manual for the portable ventilator on 7-9-15 and verbal demonstration/instructions regarding how to operate the ventilator including how to turn it on, reset the alarm button, change batteries and change the tubing. Staff were not instructed regarding ventilator settings and the agency did | S5065 | | |

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| S5065 | Continued From page 5 | S5065 | | |

not provide any type of certification training. Confirmed the agency personnel made monthly visits to the facility to check the equipment settings and bring supplies. They re-instructed staff again on 7-30-15 and 9-1-15.

Interview on 12-8-15 at 11:17 am with RN C stated neither administrative staff A or licensed practical nurse B consulted with him/her prior to accepting resident #630 for admission and he/she became aware of resident when he/she came to facility to perform monthly reviews about 3 weeks after #630 admitted. Further stated he/she voiced concerns to administrative staff A regarding resident ' s use of portable ventilator for which he/she lacked training. Stated he/she did not give any written recommendations or instructions to staff and did not seek additional training regarding use of the portable ventilator. Confirmed he/she was not directly involved in the resident ' s plan of care. Stated he/she would not have approved the resident for admission as he/she exceeded facility ' s available level of care due to use of portable ventilator. RN C stated he/she had spoken with the Kansas Board of Nursing regarding the scope of practice for the licensed practical nurse (LPN) supervising the care of resident #630 and was told the LPN could manage the ventilator-dependent resident ' s care with a physician ' s order for care of the ventilator, specialized ventilator training and RN oversight, but stated as the RN responsible for the supervision of this LPN, he/she did not have the necessary training to manage the ventilator.

Interview on 12-9-15 at 12:40 pm with administrative staff A confirmed the resident moved out of the facility on 12-9-15 at 8:00 am.

For Resident #630, the operator failed to ensure

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| S5065 | Continued From page 6<br>that a resident who required ongoing skilled nursing intervention 24 hours a day was not retained unless the negotiated service agreement (NSA) included services sufficient to meet the needs of the resident when resident #630's NSA failed to address his/her use of a portable ventilator and care of a tracheostomy and the facility failed to provide qualified staff to manage this ventilator-dependent resident ' s care 24 hours a day. This failure placed Resident #630 in immediate jeopardy. The jeopardy was removed on 12-9-15 when the resident moved from the facility. | S5065 | | |
| S5165 SS=E | 26-42-204 (e) Delegation of Duties<br><br>(e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-204(e)<br>The facility reported a census of 8 home plus residents and 2 day care residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1 (#630) sampled resident and 1 focus review resident (#633) requiring " blood sugar and insulin tracking " (blood sugar monitoring with a glucometer), a nursing procedure not included in the medication aide curriculum, the operator failed to ensure the licensed nurse delegated the procedure to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and | S5165 | | |

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| S5165 | Continued From page 7<br>amendments thereto.<br>Findings included:<br>- Review of resident records revealed 2 residents (#630, #633) required blood sugar monitoring with a glucometer.<br>Review of personnel record for certified medication aide (CMA) #F, hire date 10/3/15, revealed the record lacked documentation of education or assessment of competency by a licensed nurse for delegation of blood sugar monitoring with a glucometer.<br>Interview on 12/7/15 at 1:30 pm administration staff #A reported lack of documentation of competency check for certified medication aide (CMA) # F, and confirmed she/he passes medications/treatments.<br>Interview on 12/7/15 at 5:00 pm with licensed nurse #B confirms CMAs perform blood glucose checks and that he/she has not completed competency exams on anyone working at the facility.<br>For CMA #F, the licensed nurse failed to delegate nursing procedures (as outlined under the Kansas Nurse Practice Act 65-1124) to CMAs related to glucometer checks. | S5165 | | |
| S5185 SS=D | 26-42-206 (a) (b) (c) Dietary Services<br><br>(a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement.<br>(b) The supervisory responsibility for dietetic services shall be assigned to one employee.<br>(c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical | S5185 | | |

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| S5185 | Continued From page 8<br>record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-206(c)<br><br>The facility reported a census of 8 home plus residents and 2 day care residents. The sample included 3 residents and 1 focus review resident. Based on observation, record review and interview for 1 resident (#631) receiving mechanically altered diets and/or thickened liquids, the operator/nurse failed to ensure a medical care provider's order shall be on file in the resident's clinical record and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian.<br><br>Findings included:<br><br>- Record review for resident #631 revealed admission on 10/31/14 with diagnoses of dementia, hypertension (HTN), glaucoma, enlarged heart and Osteoarthritis (OA) of right hand.<br>The functional capacity screen dated 10/8/15 recorded resident required physical assistance with eating. The negotiated service agreement dated 10/8/15 recorded facility to provide 3 meals of mechanical soft diet, with thickened water. Speech therapy evaluation 10/14/15 recorded mechanical soft diet level with nectar-thick liquids, primary diagnosis: oropharyngeal dysphagia. Recommendation recorded for puree consistency | S5185 | | |

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| S5185 | Continued From page 9<br>and water only with one on one caregiver assist.<br>Physician ' s order (discharge assessment summary ...) dated 10/27/14 recorded order for mechanical soft diet. Physician ' s order 10/8/15 recorded order for mechanical soft diet with thickened water.<br>Interview on 12/7/15 at 1:00 pm with dietary staff #G confirmed no written instructions for mechanical soft diet.<br>Observation on 12/7/15 at 5:30 pm revealed resident eating with staff assistance from certified staff #E, meal of ground chicken, mashed cabbage, cornbread and thickened water.<br>Interview on 12/7/15 at 6:10 pm with administrative staff #A and licensed nurse #B confirmed they had not seen this report and it was not on resident ' s chart until today.<br>For resident #631, receiving a mechanically altered diet and/or thickened liquids, the operator failed to ensure the resident ' s diet and or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. | S5185 | | |
| S5205 SS=J | 26-42-104 (a) Disaster and Emergency Preparedness<br><br>a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-104(a)<br><br>The facility reported a census of 8 residents and | S5205 | | |

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2 day care residents. The sample included 3 residents and 1 focus review resident. Based on observation, record review and interview for 1 (#630) of 3 sampled residents, the operator failed to ensure the provision of a sufficient number of staff on night shift to take residents who would require assistance to a secure location when only one staff was on duty to care for all residents include #630 who required the assistance of 2 staff for transfer. This failure placed the resident in immediate jeopardy for harm, injury, or death.

Findings included:

- Review of the resident roster revealed a census of 8 residents and 2 day care residents. The roster identified 6 residents with impaired cognition and 1 resident (#630) who required 2 staff for transfers.

Interview during entrance tour on 12-3-15 at 10:05 am with administrative staff A stated " it takes at least two staff to transfer " resident #630. Stated, if resident needed to be evacuated during the middle of the night, " they (staff) would call 911 and say I need you to come help me get him/her out. " Administrative staff A confirmed that since resident ' s admission on 6-26-15, 2 staff were on duty during the day, only one certified staff member was scheduled to work the night shift and routinely from 8:00 pm until 7:00 am, there was only one certified staff scheduled. Administrative staff A further stated there was no schedule posted for review because all staff knew when to come to work.

Record review for resident #630, admitted on 6-26-15, revealed diagnoses included of

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| S5205 | Continued From page 11<br>Charcot-Marie-Tooth Disease [a hereditary disorders that damages the nerves in the arms and legs (peripheral nerves)], Quadriplegia and Osteomylitis.<br><br>Observation on 12-7-15 at 10:37 am revealed resident #630 required physical assistance of certified staff D and certified staff E to transfer from bed to electric wheelchair. Both staff were required to assist the resident out of bed and position properly and safely in the wheelchair.<br><br>Interviews on 12-7-15 at 4:30 pm and confirmed facility had not conducted a drill that included evacuation of residents with the use of 1 staff member on the night shift to determine if an evacuation could be performed safely and in a timely manner with 1 staff person.<br><br>Interview on 12-8-15 at 2:19 pm, with administrative staff A stated 2 additional residents (#631, #634) required physical assistance of one staff member to transfer into a wheelchair and evacuate the building, the remaining 5 home plus residents ambulated without assistance.<br><br>For resident #630 who required 2 staff to transfer, the operator failed to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location during the night shift when only 1 staff member was on duty. This failure placed the resident immediate jeopardy for harm, injury or death<br><br>The jeopardy was removed on 12-3-15 when two staff were scheduled on duty at all times. | S5205 | | |

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| S5300 | Continued From page 12 | S5300 | | |
| S5300 SS=E | 26-42-205 (d) (1-2) Facility Administration of Medications<br><br>(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:<br>(1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility.<br>(2) Medication aides shall not administer medication through the parenteral route.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-205(d)(1)<br><br>The facility reported a census of 8 residents and 2 day care residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 2 sampled (#630) and 1 focus review (#633) resident, the operator failed to ensure all medications and treatments were administered in accordance with a medical care provider's written order and professional standards of practice and only licensed nurses and medication aides administered and managed medications for which the home had responsibility. | S5300 | | |

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| | B105114 | A. BUILDING: _____ B. WING _____ | 12/09/2015 |

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| JOHNSONVILLE HOME LLC | 2419 N 22ND ST KANSAS CITY, KS 66104 |

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| S5300 | Continued From page 13<br>Findings included:<br><br>- Record review for resident #633 revealed admission on 7/26/06 with diagnoses of glaucoma, diabetes mellitus, benign essential hypertension, hyperlipidemia, congestive heart failure (CHF), elevated prostate-specific antigen (PSA), allergic rhinitis, benign hypertrophy, headache, esophageal reflux, benign tumor of meningioma, seizures, hearing loss, degenerative disc disease, peripheral neuropathy, back pain, asthma and edema.<br>The functional capacity screen (FCS) dated 12/24/14 recorded resident unable to perform management of medications and requiring physical assistance with management of treatments. The negotiated service agreement (NSA) dated 12/24/14 recorded services for facility staff to manage all medications and treatments as indicated by physician.<br>Review of medication administration record of December 2015 revealed documentation of administration of the following medications/treatments with no corresponding physician ' s order (on most recent physician ' s order form) dated 11/5/15: Furosemide (water pill) 20 mg tablet take one tablet by mouth every day; Vitamin D 1,000 unit ½ tablet (500 U) by mouth every day for supplement; Therems-M tablet take one tablet by mouth every day for supplement; beneprotein ' resource ' (supplement) mix 1 tablespoonful with cereal every morning; clotrimazole 1% cream apply topically to feet between toes, toenail every day until dry skin heals then as needed; refresh classic eye drops (for dry eyes) instill 1 drop into both eyes two times a day; hydrocodone/acetaminophen 5 mg/325 mg take 1 tablet by mouth at bedtime for pain (scheduled for 8 pm) not to exceed, 3 gram acetaminophen in | S5300 | | |

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| S5300 | Continued From page 14 | S5300 | | |

24 hours; remeron (anti-depressant) 15 milligrams take 1 tablet by mouth every day at bedtime; and proair HFA 90 microgram inhaler (asthma ), inhale 2 puffs by mouth every 4 hours as needed.
Interview on 12/7/15 at 5 pm with licensed nurse #B confirms: orders dated 11/5/15 are the most recent physician ' s orders, the medication record and physician ' s orders do not match, the medications/treatments have been administered, he/she readmitted resident on 11/5/15 and did not reconcile the medication/ treatment orders.
For residents #633, the operator failed to ensure all medications and treatments were administered in accordance with the physician's written order and professional standards of practice.

- Record review for resident #630 revealed admission on 6-26-15 with diagnoses Charcot-Marie-Tooth Disease, Insulin Dependent Diabetes Mellitus, Quadriplegia and Osteomyelitis of the heel.
The functional capacity screen (FCS) dated 6-26-15 recorded resident required physical assistance with management of medications and treatments. Cognition: problems with decision-making.

The negotiated service agreement/health care service plan (NSA/HCSP) dated 6-26-15 recorded Nurse, Certified Medication Aide (CMA) will manage all medications and treatments per primary care provider. " Nursing services to be provided: Medication Management, treatments, accuchecks (blood glucose monitoring) before meals and at bedtime, tracheostomy care, etc. "

Review of medication administration record of December 2015 revealed documentation of the following medications/treatments with no

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| S5300 | Continued From page 15<br>corresponding physician ' s order (most recent: summary of today ' s visit) dated 9/3/15. ferrous sulfate (iron supplement) 325 mg tablet take one tablet by mouth 3 times a day with meals as needed; and floranex (probiotic supplement) tablet take one tablet by mouth 3 times a day as needed.<br>Notebook in resident ' s room with forms labeled, " Blood Sugar and Insulin Tracking " for documentation of blood sugar readings at 8:00 am, 12:00 pm, 4:00 pm, 8:00 pm and as needed. Further documented administration of Novolog Insulin 12 units subcutaneously ordered to be given " before each meal add one unit for every 50 above 150; and Lantus insulin 15 units once day. " With instructions to " Please write what amounts were administered. If resident requests something different, please write it down. Volunteers ONLY please record and initial next to how much insulin was administered. "<br><br>Interviews on 12-3-15 and 12-7-15 with administrative staff A confirmed the facility managed all of the residents medications and that while a licensed practical nurse was available by phone for unscheduled needs, the nurse did not work regularly scheduled hours at the facility and was not available during the day to administer insulin to resident #630. Confirmed a facility non-licensed and uncertified " volunteer " performed blood glucose monitoring and administered insulin to resident as he/she was unable to self inject. This volunteer was not known to the resident prior to admission to the facility.<br>Interview on 12/7/15 at 5:30 pm with licensed nurse #B confirmed discrepancies between December 2015 medication record and current physician orders dated 9/3/15; and further confirmed that a non-licensed, uncertified | S5300 | | |

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| S5300 | Continued From page 16<br>volunteer administered insulin to the resident whose medications were managed by the facility. For residents #630, the operator failed to ensure all medications and treatments were administered in accordance with the physician's written order and professional standards of practice; and only licensed nurses and medication aides administered and managed medications for which the home had responsibility. | S5300 | | |
| S5315 SS=E | 26-42-205 (h) Medication Storage<br><br>(h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations.<br>(1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals.<br>(2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides.<br>(3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be | S5315 | | |

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| S5315 | Continued From page 17<br>stored by the home.<br>(4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.<br><br>This REQUIREMENT is not met as evidenced by:<br>5315 KAR 26-42-205(h)<br><br>The facility reported a census of 8 residents and 2 day care residents. The sample included 3 residents and 1 focus review resident. Based on observation and interview for 1 of 1 bottle of TB solution, licensed nurses and medication aides failed to ensure that all medications and biologicals are properly stored in accordance with each manufacturer's recommendations, and not administered beyond the manufacturer's date of expiration.<br><br>Findings included:<br><br>- Observations on 12/3/15 at 11:12 pm, in the facility refrigerator, revealed an opened bottle of TB solution, date filled 7/17/15. The date opened and initially used not available.<br><br>Interview on 12/3/15 at 11:12 pm with operator confirmed the bottle had no date when opened and was half empty. . Further stated he/she did not realize the solution had to be discarded after 30 days per manufacturer's recommendation.<br><br>Licensed nurses and medication aides failed to ensure that TB solution was stored in accordance with the manufacturer's recommendations to discard after vial opened 30 days. | S5315 | | |

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