STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089086	A. BUILDING: _____ B. WING _____	12/09/2015

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HILLSDALE PLACE LLC	1402 SW LANCASTER ST TOPEKA, KS 66604

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S 000	INITIAL COMMENTS The following citations are the result of a Licensure Resurvey at the above named Home Plus Facility in Topeka, Kansas on 12/07/15, 12/08/15, and 12/09/15. Complaint #90573 also investigated.	S 000		
S5265 SS=D	26-42-205 (a) (1) Medication Self Administration Assessment (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(a) The census equalled six the sample included three Residents. The Resident roster identified all Residents as receiving medication management. Based on observation, interview, and record review, for one of one sampled with self	S5265		

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

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S5265	Continued From page 1 administered medications (#187), the Operator failed to ensure a licensed nurse performed an assessment to determine the Resident could safely and accurately administer medications without staff assistance. Findings included: - Review of record revealed #187 admitted to facility 6/01/15 with diagnoses of Dementia, Debility, Gait instability, Hypertension, Parkinson's, Diabetes, Hyperlipidemia, Gastroesophageal reflux disease, Hypothyroidism, and Hypotension. Current functional capacity screen (FCS) of 6/01/15 assessed #187 unable to perform (3) treatment management, and in need of supervision (1) with medication management. The negotiated service agreement (NSA) of 5/03/14 documented facility staff to set up and dispense all medications. On 12/08/15 at 10:20am, in #187's room, observed wash basin in entertainment center with various topical ointments, lotions, and powders. Items included Neosporin ointment, Lotrimin powder, "Z guard" and various skin barrier creams. Observed an in use tube of petroleum ointment (like Vaseline) on bedside table. #187 stated I use that tube (petroleum ointment) on my bottom when I need it... I am not using any of those right now (indicated wash basin of topicals)... accumulated those from previous stays at hospitals and rehab centers... want to keep them in case I do need them but not using right now... On 112/08/15 at 5:35pm, Operator/Certified	S5265		

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S5265	Continued From page 2 Medication Aide #C stated I was not aware of those items being in room... I will have the nurse complete a self administration assessment... then can determine if he/she can keep those in room... #C confirmed self administration of any medication or treatment not included on Resident's NSA. The Operator failed to ensure a licensed nurse performed an assessment of #187's ability to safely self administer medications.	S5265		
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 census equalled six the sample included	S5300		

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S5300	Continued From page 3	S5300		

three Residents. The Resident roster identified all Residents as receiving medication management. Based on interview and record review, for one of three sampled with medication management (#189), the Operator failed to ensure all medications and biologicals administered to Residents in accordance with written medical care provider orders, and in accordance with professional standards of practice.

Findings included:

- Review of record revealed #189 admitted to facility 5/03/14 with diagnoses of Hypertension, Anxiety, and Urinary frequency.

The current functional capacity screen (FCS) of 8/21/15 assessed #189 unable to perform medication and treatment management.
The negotiated service agreement (NSA) of 3/09/15 documented facility staff to manage all medications.

Comparison of the December 2015 MAR (medication adminsitration record) with written physician's order revealed a discrepancy:
MAR documented: Calcium Carbonate 600mg chew one tablet by mouth daily; and Vitamin d3 400 international units take 2 tabs by mouth daily.
A phone order in medical record recorded:
12/01/15 - Calcium Carbonate to 600mg po (by mouth) daily (combo tab with vitamin D3 800 iu tabs)
12/02/15 - Medical care provider signed the phone order
12/08/15 - Registered Nurse (RN) #F added a note to the signed phone order "12/8/15 - Clarification - med not chewable with initials of #F."
This practice demonstrated the failure to utilize

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S5300	Continued From page 4 professional standards of practice in the clarification of a physician's written order. Comparison of the count/reconciliation sheet for Resident's Clonazepam with the physical number of tablets in the bottle on 12/07/15 revealed a discrepancy. Clonazepam 1mg - count sheet recorded 47 doses; counted tablets from bottle contained 51 doses Re-check of the count/reconciliation sheet for Resident's Clonazepam with the physical number of tablets in the bottle on 12/08/15 revealed a discrepancy. The December 2015 MAR (medication administration record) with written 5/03/14 physician's order for Clonazepam 1mg (milligram) one tablet po (by mouth) TID (three times a day) AM, NOON, HS (morning, noon, bedtime) for anxiety. The MAR documented these doses administered at 8:00am, 12:00pm, and 8:00pm. On 12/08/15 at 9:28am Surveyor introduced to facility nurse Registered Nurse (RN) #F. Operator/CMA #C and RN #F stated had reconciled narcotic count sheets. By review on 12/08/15 at 11:14am: #189 - Clonazepam 1mg - counted tablets from bottle now at 48 tablets. Bottle count prior evening 12/07/15 at 4:55pm revealed 51 tablets. One dose documented administered by CMA #D at 2000 on 12/07/15 with count remaining "46" (count remaining should have been 50 tablets) One dose documented administered by CMA #C at 0800 on 12/08/15 with count remaining "45" (count remaining should have been 49 tablets) Count/reconciliation sheet contained a note by RN #F "reconciled - reason unsure +3 12/08/15	S5300		

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S5300	Continued From page 5 0900." This demonstrated the failure to investigate, evaluate, and correct the cause of discrepancies in accordance with professional standards of practice. When asked how count went from four long to one short, Operator/CMA #C stated maybe we dropped it in the trash, or got swept up by accident... I told CMA #D last night the meds are off we will reconcile with RN in the morning, don't bother counting... I told the RN we were three off... By observation at 11:15am, Operator/CMA #C searched trash bag... located a pill in trash, but identified as a blood pressure medication for #187, and not the Clonazepam for #189. At this time Operator/CMA #C stated I gave one dose at 8:00am... the RN #F and I counted... I said "No we are 3 pills off... I told #F we were 3 off last night... so I went and geve #187 another pill... approximately 8:30 or 9:00am... thought we had three extra... when we counted four extra thought maybe I hadn't given the 8:00am dose and went and gave the extra... I know now I gave one at 8:00am and another at 8:30 or 9:00am... I will have the nurse notify the physician and the family of the medication error. The Operator failed to ensure all medications and biologicals administered to #189 in accordance with written medical care provider orders and in accordance with professional standards of practice.	S5300		
S5301 SS=D	26-42-205 (d) (3) Facility Administration of Medications	S5301		

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S5301	Continued From page 6 (d) (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(3) The census equalled six the sample included three Residents. The Resident roster identified all Residents as receiving medication management. Based on observation and record review, for one of three sampled with medication management (#187), the Operator failed to ensure all Licensed nurses and Certified Medication Aides (CMA's) remained with the Resident until medication ingested. Findings included: - Review of record revealed #187 admitted to facility 6/01/15 with diagnoses of Dementia, Debility, Gait instability, Hypertension,	S5301		

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S5301	Continued From page 7 Parkinson's, Diabetes, Hyperlipidemia, Gastroesophageal reflux disease, Hypothyroidism, and Hypotension. Current functional capacity screen (FCS) of 6/01/15 assessed #187 unable to perform (3) treatment management, and in need of supervision (1) with medication management. The negotiated service agreement (NSA) of 5/03/14 documented facility staff to manage medications for Resident. On 12/08/15 at 12:14pm Operator/CMA #C placed white souffle pill cup, with assorted pills and tablets inside, next to #187's dinner plate during the noon meal in the dining room. Operator/CMA #C then returned to the medication cart, located in the laundry area of facility, and proceeded to document in MAR (medication administration record) and open drawers of cart to prepare additional medications. This medication cart/laundry area located on one side of kitchen, and dining room and table on the opposite side of facility kitchen. #187 sat at the far left end of dining table (left when looking at table from the kitchen and/or laundry area) not in line of vision from the medication cart in laundry area. On 12/08/15 at 12:17pm, after finishing items on dinner plate, #187 picked up the medication container and poured the assorted pills and tablets in his/her mouth and took the medications with drink at the table. The Operator failed to ensure all Licensed nurses and CMA's remained with #187 until medication ingested.	S5301		

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S5313	Continued From page 8	S5313		
S5313 SS=F	26-42-205 (g) (3) Over the counter medication (g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(3) The census equalled six the sampled included three Residents. The Resident roster identified all Residents as receiving medication management. Based on observations and interviews, for two of three sampled (#185 and #189) and two non-sampled (#180 and #182), the Operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of Resident on full packages of over-the-counter medications. Findings included: - On 12/08/15 at 10:00am, observations of specific medication drawer contents revealed nearly all over-the-counter medications lacked the name of the Resident to whom the medication belonged:	S5313		

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S5313	Continued From page 9 Drawer of #189 - Walitin (generic Claritin); Cranberry tablets; Anefrin (generic nasal spray); Immodium (anti diarrhea); Urinary relief (generic pyridine); Biofreeze spray (topical pain relief spray); Ibuprofen tablets; all without a name on package. Drawer of #180 - Package of 81 milligram aspirin tablets, no name on package. Drawer of #182 - Walgreen Vitamin d3 1000 units, no name on package Drawer of #185 - Package of 81 milligram aspirin tablets; Vitamin D3 1000 units; Vitamin B Complex; Vitamin C 500 milligrams (expired February 2013); Blink tears (eye drops); Systane Ultra (eye drops, expired October 2015); Phillips milk of magnesia capsules; Acetaminophen tablets; all without a name on package. Bottom drawer of cart contained multiple packages without names: Bottle of chewable calcium carbonate antacid tablets (generic Tums); Robitussin Maximum Strength; bottle of Magnesium Citrate (strong laxative, expired March 2014); two Milk of magnesia bottles. On 12/08/15 at 10:00am, Operator/Certified Medication Aide (CMA) #C picked up a permanent marker and prepared to place names on packages. Surveyor alerted #C to requirement that licensed nurse or licensed pharmacist write the name on packages. Operator/CMA #C stated the family often times brings these in... some we do not have orders for and do not give... I was not aware the nurse had to write the name on the package. Operator/CMA #C stated the items in the bottom drawer I keep on hand in case Residents need... #C then stated those in bottom	S5313		

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S5313	Continued From page 10 drawer are used for myself and staff not for Residents. By review of facility Medication Administration policy and procedure: "All over-the-counter medications will be labeled with Resident's full name and date when opened." The Operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of Resident on full packages of over-the-counter medications for #189, #185, #182, and #180.	S5313		
S5316 SS=F	26-42-205 (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 home 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 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.	S5316		

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S5316	Continued From page 11 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(i) The census equalled six the sample included three Residents. The Resident roster identified all Residents with facility managed medications. Based on observations, interviews, and reviews of records, for two of two controlled medication reconciliation reviews, and for three of three sampled Residents receiving medications (#189, #187, and #185), and for one non-sampled Resident (#184), the Licensed nurses and Certified Medication aides (CMA's) failed to follow facility policy and procedure and standards of practice to ensure an accurate accounting of controlled medications. Findings included: - Observation on 12/07/15 at 4:55pm with Operator/CMA #C revealed inaccurate counts of Escitalopram and Morphine for #184, no documentation for 30 one-half tabs of Morphine and no documentation for 30 tablets of Alprazolam for #184; inaccurate count of Clonazepam for #189. According to count/reconciliation records maintained by facility for #184: Escitalopram 10mg (milligrams) - count sheet recorded 16 tablets; punch card contained 15 tablets Operator/CMA #C stated the pills were delivered	S5316		

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S5316	Continued From page 12 11/24/15... I should have circled that dose and I didn't... I am only one who has administered... According to count/reconciliation records maintained by facility for #184: Morphine 15mg - no page or documentation for card with 30 half tablet doses (7.5mg) Morphine 15mg - count sheet recorded 26 doses for 8:00pm; punch card contained 27 doses Morphine 15mg half tablets - count sheet recorded 26 doses for 2:00am; punch card contained 27 doses Alprazolam - no page or documentation for card with 30 tablet doses According to count/reconciliation records maintained by facility for #189: Clonazepam 1mg - count sheet recorded 47 doses; counted tablets from bottle contained 51 doses Operator/CMA #C stated we only make up a count sheet when the previous card runs out... do not make up a sheet when the medication arrives at facility... I'm not counting because I and CMA #D are the only ones passing medications... "recently they (Residents) have been interrupting me... so I told them like you can't bother me I have to do med pass"... On 12/08/15 at 9:28am Surveyor introduced to facility nurse Registered Nurse (RN) #F. Operator/CMA #C and RN #F stated had reconciled narcotic count sheets. By review on 12/08/15 at 11:14am: #189 - Clonazepam 1mg - counted tablets from bottle now at 48 tablets. Bottle count prior evening 12/07/15 at 4:55pm revealed 51 tablets.	S5316		

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S5316	Continued From page 13 One dose documented administered by CMA #D at 2000 on 12/07/15 with count remaining "46" (count remaining should have been 50 tablets) One dose documented administered by CMA #C at 0800 on 12/08/15 with count remaining "45" (count remaining should have been 49 tablets) Count/reconciliation sheet contained a note by RN #F "reconciled - reason unsure +3 12/08/15 0900." When asked how count went from four long to one short, Operator/CMA #C stated maybe we dropped it in the trash, or got swept up by accident... I told CMA #D last night the meds are off we will reconcile with RN in the morning, don't bother counting... I told the RN we were three off... By observation at 11:15am, Operator/CMA #C searched trash bag... located a pill in trash, but identified as a blood pressure medication for #187, and not the Clonazepam for #189. At this time Operator/CMA #C stated I gave one dose at 8:00am... the RN #F and I counted... I said "No we are 3 pills off... I told #F we were 3 off last night... so I went and geve #187 another pill... approximately 8:30 or 9:00am... thought we had three extra... when we counted four extra thought maybe I hadn't given the 8:00am dose and went and gave the extra... I know now I gave one at 8:00am and another at 8:30 or 9:00am... By review on 12/08/15 at 11:30am: #184 - Morphine 15mg one half tabs (7.5mg) - PRN (as needed) card contained 30 doses, now with accompanying count sheet that documented 30 doses. #184 - Morphine 15mg one half tabs (7.5mg) - 0200 punch card contained 25 doses (contained 27 doses prior eveing 12/07/15 at 4:55pm), the	S5316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089086	A. BUILDING: _____ B. WING _____	12/09/2015

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S5316	Continued From page 14	S5316		

count sheet documented 25 doses.
One dose documented administered at 0300 on 12/08/15 by CMA #C, with count at 25. (This administration should have resulted in 26 tablets remaining).
No documentation or explanation of process count sheet went from one tablet too many, to one tablet too few.
Operator/CMA #C stated I don't know what happened to other dose... "I know I gave him/her one this morning."

By review on 12/08/15 at 11:40am:
#184 - Escitalopram 10mg - 8:00am punch card contained 15 doses (contained 15 doses prior evening 12/07/15 at 4:55pm), the count sheet now documented 15 doses also.
One dose documented administered at 0800 on 12/08/15 by CMA #C, with count at 15. (This administration should have resulted in 14 tablets remaining).
No documentation or explanation of process count sheet went from one tablet long to correct count.
Operator/CMA #C stated I gave one this morning and counted... don't know how it could be off...

#184 - Morphine 15mg - 8:00pm punch card contained 26 doses/tablets, the same number documented at 4:55pm on 12/07/15.
One dose documented administered at 2000 on 12/07/15 by CMA #D, with count at 25.
Note added by RN #F "Reconciled med 12/3 not given add +1" with number 25 now changed to 26 tablets.

By review of sampled Resident records on 12/08/15, #187 and #185 each with documented routine administration of the medication Ritalin (a schedule II controlled medication). By review, the

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S5316	Continued From page 15 controlled medication count sheets failed to include the medications for these two Residents. On 12/08/15 at 5:00pm, Operator/CMA #C stated we are not counting Ritalin for #187 and #185... I don't think it's on the list of medications to count... I will have to look it up... By review on 12/09/15, the facility Medication Administration policy and procedure documented: All medications will be administered to each Resident in accordance with a physician's written ordered" All medications received and destroyed will have proper records so there are accurate records for reconciliation. All narcotics will be counted by staff coming on with staff leaving each shift changed. If staff fines any errors with narcotic counts the staff leaving will not leave until the discrepancy is solved. Executive Director and Resident Service Director will be notified as soon as possible. The CMA's and licensed nurses failed to follow the facility policies and procedures related to medication administration and disposition. The Licensed nurses and Medication aide failed to follow facility policy and procedure and standards of practice to ensure an accurate accounting of controlled medications for #185, #187, #189, and #184.	S5316		