STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087183	A. BUILDING: _____ B. WING _____	08/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHENEY GOLDEN AGE HOME PLUS	802 NORTH MAIN STREET CHENEY, KS 67025

(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 of the above home plus facility on 7/29/15, 7/30/15, and 8/3/15.	S 000		
S5085 SS=F	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c)(1)(2) The facility reported a census of 6 residents. The sample included 3 residents. Based on record review, observation, and interview for 2 (#106 and #102) of 2 residents sampled who lived in the facility for more than 365 days, the licensed nurse failed to conduct a screening to determine each resident's functional capacity at least once every 365 days and following any significant change in condition as defined in K.A.R. 26-39-100. Findings included: - Record review for resident #106 revealed an admission date of 6/21/11 and diagnoses of vascular dementia with psychosis and delusions, anxiety, and agitation. The record contained documentation by a licensed nurse on 7/12/15 at	S5085		

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

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S5085	Continued From page 1 9:20 p.m. that staff found resident on floor at bedside, resident complained of right leg pain, resident was sent to hospital for evaluation. On 7/15/15 osteoporosis and fractured femur were added to the resident's list of diagnoses . The record contained a functional capacity screen dated 7/8/13 that indicated the resident was independent with eating; required physical assistance with bathing, dressing, toileting, transferring, and mobility; was unable to perform management of medications and treatments; was frequently incontinent of urine; experienced impaired short-term memory, long-term memory, decision making, and memory recall; was at risk for falls; and required a wheelchair for mobility. The record lacked an annual or significant change functional capacity screen. Review of the resident roster revealed resident #106 required 2 staff members to transfer. At 11:40 a.m. on 7/29/15, observed resident #106 in a wheelchair at the dining room table. Observed right leg elevated with a blanket covering resident's legs. Certified staff #G fed lunch to resident who did not attempt to feed self. At 3:10 p.m. on 7/29/15, licensed nurse #A and licensed nurse #B each confirmed a functional capacity screen had not been conducted at least every 365 days and with a significant change in functioning. During an interview at 4:10 p.m. on 7/29/15, certified staff #H stated staff fed resident meals when resident would not feed self. Due to leg fracture resident required full assistance with transfer and was not toileted since resident could not bear weight during transfer.	S5085		

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S5085	Continued From page 2 The licensed nurse failed to conduct a screening to determine resident #106's functional capacity according at least once every 365 days and following any significant change in condition as defined in K.A.R. 26-39-100. - Record review for resident #102 revealed an admission date of 4/23/14 and diagnoses of senile dementia, diabetes mellitus type II, hypertension, and osteoporosis. The record contained a functional capacity screen dated 4/23/14 that indicated the resident required supervision with eating; physical assistance with bathing, dressing, toileting, transferring, and mobility; was unable to perform management of medications and treatments; was usually continent of urine; experienced impaired short-term memory, long-term memory, decision making, and memory recall; and used a walker and wheelchair for mobility. The record lacked an annual or significant change functional capacity screen. Review of the resident roster revealed resident #106 required 2 staff members to transfer. At 12:30 p.m. on 7/29/15, observed licensed nurse #A and certified staff #G transfer resident from recliner in living room to wheelchair. Resident did not bear weight or assist with transfer. At 1:00 p.m. on 7/29/15, observed certified staff #G feeding lunch to resident. During an interview at 3:15 p.m. on 7/29/15, licensed nurse #A stated resident was unable to perform bathing, dressing, and mobility and required physical assistance with eating. Licensed nurse #A stated resident experienced a	S5085		

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S5085	Continued From page 3 significant change in functioning and confirmed a functional capacity screen was not conducted. At 4:10 p.m. on 7/29/15, certified staff #H stated resident required feeding assistance when resident would not feed self. Certified staff #H stated resident required 2 staff members to transfer. The licensed nurse failed to conduct a screening to determine resident #102's functional capacity according at least once every 365 days and following any significant change in condition as defined in K.A.R. 26-39-100.	S5085		
S5105 SS=D	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)(2)(3)	S5105		

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S5105	Continued From page 4 The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 1 (#102) of 3 residents sampled, the administrator failed to ensure the development of a written negotiated service agreement for the resident, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's legal representative, the case manager, and, if agreed to by the resident or the resident's legal representative, the resident's family that included the description of services provided by an outside resource, the identification of the outside resource, and identification of the party responsible for payment to the outside resource. Findings included: - Record review for resident #102 revealed an admission date of 4/23/14 and diagnoses of senile dementia, diabetes mellitus type II, hypertension, and osteoporosis. The record contained a functional capacity screen dated 4/23/14 that indicated the resident required supervision with eating; physical assistance with bathing, dressing, toileting, transferring, and mobility; was unable to perform management of medications and treatments; was usually continent of urine; experienced impaired short-term memory, long-term memory, decision making, and memory recall; and used a walker and wheelchair for mobility. The record lacked an annual or significant change functional capacity screen. The amended negotiated service agreement and health care service plan dated 7/3/15	S5105		

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S5105	Continued From page 5 documented facility staff provided personal care of assistance with bathing, dressing, and incontinence care, stand-up lift as needed for transfers; medication administration; and monitor skin integrity. The resident's record contained documentation of hospice services with a start of care date of 12/21/14. The resident's negotiated service agreement lacked a description of services provided by hospice, the name of the hospice, and the party responsible for payment of the hospice services. At 3:15 p.m. on 7/29/15, licensed nurse #A stated resident continued to receive hospice services of skilled nursing and home health aide visits. Licensed nurse #A confirmed the resident's negotiated service agreement lacked a description of hospice services, the name of the hospice, and the party responsible for payment of the hospice services. The administrator failed to ensure the development of a written negotiated service agreement for resident #102, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's legal representative, the case manager, and, if agreed to by the resident or the resident's legal representative, the resident's family that included the description of services provided by an outside resource, the identification of the outside resource, and identification of the party responsible for payment to the outside resource.	S5105		
S5165 SS=F	26-42-204 (e) Delegation of Duties	S5165		

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S5165	Continued From page 6 (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. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(e) The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 1 (sampled resident #101) of 1 resident requiring blood sugar monitoring with a glucometer, a licensed nurse failed to delegate a nursing procedure not included in the medication aide curriculum to medication aides performing the test under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included: - Record review for resident #104 revealed an admission date of 5/7/15 and diagnoses of type II diabetes mellitus, atrial fibrillation, hypertension, and Alzheimer's dementia. The resident's functional capacity screen dated 5/7/15 indicated the resident was unable to perform management of medications and treatments. The addendum to the negotiated service agreement dated 5/7/15 documented the resident required the service of blood sugar monitoring. The record contained a medical care provider's order for fasting blood sugar two times a week and as needed. Review of 3 certified medication aide employee files (#C, #D, and #E) at 12:45 p.m. on 7/29/15	S5165		

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S5165	Continued From page 7 with the administrator revealed the lack of documentation of licensed nurse delegation to certified medication aides to perform blood sugar testing with a glucometer. At 2:00 p.m. on 7/29/15, the administrator stated a licensed nurse did not delegate glucometer testing to certified medication aides. During a phone interview at 9:30 a.m. on 7/30/15, licensed nurse #A stated 2 certified medication aides (#C and #F) performed the routine two times a week glucometer testing of resident. A licensed nurse failed to delegate a nursing procedure not included in the medication aide curriculum to medication aides performing blood sugar testing with a glucometer under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S5165		
S5171 SS=F	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(i) The facility reported a census of 6 residents, the sample included 3 residents. Based on record review and interview for 1 (#104) of 1 cognitively impaired sampled resident who received an anti-anxiety medication, the administrator failed to ensure health care services were provided to the resident in accordance with acceptable standards	S5171		

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S5171	Continued From page 8	S5171		

of practice when certified medication aides administered the anti-anxiety medication on an as needed basis without a licensed nurse assessment of the resident.

Findings included:

- Record review for resident #104 revealed an admission date of 5/7/15 and diagnoses of Alzheimer's disease, diabetes mellitus type II, atrial fibrillation, and hypertension.

The functional capacity screen dated 5/7/15 indicated the resident required supervision with transfer, walking, and eating; physical assistance with bathing, dressing, and toileting; was unable to perform management of medications and treatments; was occasionally incontinent of urine; experienced impaired short-term memory, long-term memory, decision making, and memory recall; was at risk for falls due to unsteadiness; and exhibited wandering behavior.

The negotiated service agreement dated 5/7/15 documented management of medications and management of behavioral symptoms. The addendum to the negotiated service agreement dated 5/7/15 documented the resident required monitoring of wandering behavior and wore a code alert to sound when near exit doors and due to memory impairment required staff intervention.

Review of the 7/1/15 through 7/31/15 medication administration record (MAR) and the medical care provider ' s order revealed the resident received lorazepam (anti-anxiety medication) 0.5 milligram (mg) 1 tablet by mouth every 3 hours as needed for anxiety. The 7/1/15 through 7/31/15 MAR contained documentation of administration of lorazepam by certified medication aides (CMA)

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S5171	Continued From page 9 as follows: 7/5/15 at 4:00 p.m. Lorazepam 0.5 mg for anxiety and resident resting at 5:30 p.m. The record lacked an assessment by a licensed nurse and instruction to CMA to administer lorazepam. 7/6/15 at 2:30 a.m. Lorazepam 0.5 mg for anxiety and resident asleep at 3:30 a.m. The record lacked an assessment by a licensed nurse and instruction to CMA to administer lorazepam. 7/10/15 at 3:00 p.m. Lorazepam 0.5 mg for anxiety and no relief at 4:00 p.m. The nurse's notes contained documentation by a CMA at 9:25 p.m. for the 2:00 p.m. to 10:00 p.m. shift of resident very anxious since 2:00 p.m. with trying to leave, taking other resident's belongings, and grabbing other residents. CMA documented interventions of calling an employee from the long term care facility to sit with resident, offered snacks to resident, called resident's family member, and tried activities all with no relief. The record lacked an assessment by a licensed nurse and instruction to CMA to administer lorazepam. 7/11/10 at 10:00 a.m. Lorazepam 0.5 mg for anxiety with some relief at 11:00 a.m. A CMA documented in the nurse's notes for the 6:00 a.m. to 2:00 p.m. shift of resident trying to leave facility and very anxious prior to giving lorazepam. The record lacked an assessment by a licensed nurse and instruction to CMA to administer lorazepam. 7/15/15 at 7:20 p.m. Lorazepam for anxiety with no relief at 8:50 p.m. The nurse's notes contained documentation by a CMA at 9:05 on 7/15/15 that resident had been anxious since after evening meal wandering in halls and resident rooms and trying to go out exit doors.	S5171		

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S5171	Continued From page 10 CMA documented redirection, snacks, and activities did not work to calm resident. The record lacked an assessment by a licensed nurse and instruction to CMA to administer lorazepam. 7/19/15 at 1:30 p.m. Lorazepam "for anxiety and very anxious" and "less anxious" at 3:00 p.m. CMA documented in the nurse's notes resident tried to leave facility out the front door. The record lacked an assessment by a licensed nurse and instruction to CMA to administer lorazepam. 7/25/15 at 3:00 p.m. Lorazepam 0.5 mg for anxiety with no relief at 4:00 p.m. The record lacked an assessment by a licensed nurse and instruction to CMA to administer lorazepam. 7/26/15 at 4:15 p.m. Lorazepam 0.5 mg for anxiety with no relief at 5:15 p.m. The record lacked an assessment by a licensed nurse and instruction to CMA to administer lorazepam. 7/28/15 at 3:00 p.m. Lorazepam 0.5 mg for anxiety. (No follow-up documented regarding resident's response to medication). CMA documented in the nurse's notes that between 2:00 p.m. and 3:15 p.m. resident attempted to dump another resident out of recliner 2 different times, taking another resident's blanket, and tried to leave facility 3 times. CMA documented 2 employees came from the long term care facility to assist with resident until 4:00 p.m. CMA documented resident rearranged furniture, pushed staff and squeezed and twisted staff member's arms. The record lacked an assessment by a licensed nurse and instruction to CMA to administer lorazepam. 7/28/15 at 11:00 p.m. Lorazepam 0.5 mg for anxiety and asleep at midnight. CMA	S5171		

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S5171	Continued From page 11 documented in the nurse's notes that resident would not stay in bed so gave lorazepam at 11:00 p.m. The record lacked an assessment by a licensed nurse and instruction to CMA to administer lorazepam. At 2:35 p.m. on 7/29/15, licensed nurse #A stated a licensed nurse did not assess the resident prior to administration of the lorazepam. Licensed nurse #A stated the CMA decided if the resident needed the lorazepam. During a telephone interview at 5:00 a.m. on 7/30/15, CMA #C stated he/she did not call the licensed nurse prior to giving resident lorazepam as needed. CMA #C stated that it has always been the practice for CMA to determine if resident needs the medication. The administrator failed to ensure health care services were provided to resident #104 in accordance with acceptable standards of practice when certified medication aides administered anti-anxiety medication on an as needed basis without a licensed nurse assessment of the resident.	S5171		
S5205 SS=F	26-42-104 (a) Disaster and Emergency Preparedness 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. This REQUIREMENT is not met as evidenced by:	S5205		

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S5205	Continued From page 12 KAR 26-42-104(a) The facility reported a census of 6 residents. The sample included 3 residents. Based on record review, interview, and observation for 2 (#106 and #102) of 2 sampled residents and 1 (#101) of 1 non-sampled resident who required a mechanical lift and 2 staff members to transfer, and 1 (#104) of 1 sampled resident who required staff direction and supervision due to dementia, the administrator failed to ensure a sufficient number of staff members to take all residents to a secure location in an emergency or disaster when only 1 staff member was scheduled from 10:00 p.m. to 6:00 a.m. Findings included: - Review of the resident roster completed by licensed nurse #A revealed residents #101, #102, and #106 required two staff members to transfer. During tour of the facility at 9:50 a.m. with the administrator, observed a mechanical lift in resident #101's room and a mechanical lift in resident #102's bathroom. At 9:55 a.m. on 7/29/15, licensed nurse #A stated he/she worked from 6:00 a.m. to 2:00 p.m. with a certified staff member, 2 certified staff members worked 2:00 p.m. to 10:00 p.m., and 1 certified staff member worked from 10:00 p.m. to 6:00 a.m. Licensed nurse #A stated if residents requiring two-person transfer assistance needed to be transferred from bed during the 10:00 p.m. to 6:00 a.m. shift a second person would need to come from the long-term care facility to assist with the transfers. At 10:10 a.m. on 7/29/15, the administrator and	S5205		

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S5205	Continued From page 13 licensed nurse #A could not find documentation of emergency drills with evacuation of residents to a secure location in the last 24 months. Administrator stated he/she did not know if there had ever been a drill with one person evacuating residents to a secure location. - Record review for resident #106 revealed an admission date of 6/21/11 and diagnoses of vascular dementia with psychosis and delusions, anxiety, and agitation. The record contained documentation by a licensed nurse on 7/12/15 at 9:20 p.m. that staff found resident on floor at bedside, resident complained of right leg pain, resident was sent to hospital for evaluation. On 7/15/15 osteoporosis and fractured femur were added to the resident's list of diagnoses . The record contained a functional capacity screen dated 7/8/13 that indicated the resident required physical assistance with transferring and mobility; required a wheelchair for mobility; and experienced impaired short-term memory, long-term memory, decision making, and memory recall. At 11:40 a.m. on 7/29/15, observed resident #106 in a wheelchair at the dining room table. Observed right leg elevated with a blanket covering resident's legs. During an interview at 4:10 p.m. on 7/29/15, certified staff #H stated due to leg fracture resident required full assistance with transfer and could not bear weight during transfer. - Record review for resident #102 revealed an admission date of 4/23/14 and diagnoses of senile dementia, diabetes mellitus type II,	S5205		

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S5205	Continued From page 14	S5205		

hypertension, and osteoporosis.

The record contained a functional capacity screen dated 4/23/14 that indicated the resident required physical assistance with transferring, and mobility; used a walker and wheelchair for mobility; and experienced impaired short-term memory, long-term memory, decision making, and memory recall.

At 12:30 p.m. on 7/29/15, observed licensed nurse #A and certified staff #G transfer resident from recliner in living room to wheelchair. Resident did not bear weight or assist with transfer.

At 4:10 p.m. on 7/29/15, certified staff #H stated resident required 2 staff members to transfer.

- At 3:50 p.m. on 7/29/15, interviewed resident #101 in the resident's room. Resident confirmed he/she required physical assistance from 2 staff members and the mechanical lift for all transfers.

During a telephone interview at 5:00 a.m. on 7/30/15, certified staff #C stated he/she had participated in an emergency drill to evacuate residents and was able to do this without the assistance of another employee about a year ago. Certified staff #C stated he/she could take residents to a secure location without additional staff members to assist as follows:

Resident #101: could transfer resident with mechanical lift.

Resident #102: certified staff #C stated resident is small and could transfer resident by self without use of the mechanical lift.

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S5205	Continued From page 15 Resident #106: due to fractured leg it would take some time to get resident into a wheelchair with one person. Certified staff #C stated he/she had not participated in a transfer of resident since resident fractured leg. Resident #104: certified staff #C stated resident could walk independently but due to dementia (resident) cannot follow direction. Residents #103 and #105: could walk independently and follow verbal directions. At 10:55 a.m. on 7/30/15, the administrator provided a written plan to provide adequate staffing with 2 or more individuals working each shift in the facility. The administrator failed to ensure a sufficient number of staff members to take all residents to a secure location in an emergency or disaster when only 1 staff member was scheduled from 10:00 p.m. to 6:00 a.m.	S5205		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents;	S5215		

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S5215	Continued From page 16 and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3)(4) The facility reported a census of 6 residents. The sample included 3 residents. Based on interview and record review for all residents and employees, the administrator failed to ensure disaster and emergency preparedness by ensuring the performance of a quarterly review of the facility's emergency management plan with employees and residents and that an annual emergency drill was conducted with employees and residents that included evacuation of residents to a secure location. Findings included: - At 10:10 a.m. on 7/29/15, licensed nurse #A provided documentation that the last review of the emergency management plan with employees and residents was September 2013. Administrator confirmed the emergency management plan was not reviewed quarterly with employees and residents. Licensed nurse #A and the administrator could not provide documentation of an annual emergency drill with evacuation of residents to a secure location. For all residents and employees, the	S5215		

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S5215	Continued From page 17 administrator failed to ensure disaster and emergency preparedness by ensuring the performance of a quarterly review of the facility's emergency management plan with employees and residents and that an annual emergency drill was conducted with employees and residents that included evacuation of residents to a secure location.	S5215		
S5230 SS=E	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-207(c) The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 3 (#102, #104, and #106) of 3 residents sampled, the administrator failed to ensure the facility's compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R.	S5230		

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S5230	Continued From page 18 26-39-105. Findings included: - Record review for resident #102 revealed an admission date of 4/23/14. The record contained documentation from another adult care home of a TB skin test performed on 6/6/12 and 6/26/12 and a TB symptom screen dated 9/2/13 from another adult care home. The resident's record lacked documentation of TB testing and TB symptom screen at the time of admission (4/23/14) to the facility. - Record review for resident #104 revealed an admission date of 5/7/15. The record contained documentation from another adult care home of a TB skin test performed 9/17/13 and 9/27/13. The resident's record lacked documentation of TB testing and TB symptom screen at the time of admission (5/7/15) to the facility. - Record review for resident #106 revealed an admission date of 6/21/11. The record contained documentation of a TB skin test on 5/31/11 and 6/9/11. The record lacked additional annual TB skin testing or an annual TB symptoms screen. At 3:00 p.m. on 7/29/15, licensed nurse #B stated he/she did not perform TB skin testing for resident's #102 and #104 on admission and did not complete annual TB symptoms screens for resident #106. The administrator failed to ensure the facility's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S5230		

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S5314	Continued From page 19	S5314		
S5314 SS=F	26-42-205 (g) (4) Sample & Indigent Medication Program Meds (g) (4) Licensed nurses and medication aides may administer sample medications and medications from indigent medication programs if the administrator or operator ensures the development of policies and implementation of procedures for receiving and identifying sample medications and medications from indigent medication programs that include all of the following conditions: (A) The medication is not a controlled medication. (B) A medical care provider ' s written order accompanies the medication, stating the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration. (C) A licensed nurse or medication aide receives the medication in its original, unbroken manufacturer ' s package. (D) A licensed nurse documents receipt of the medication by entering the resident ' s name and the medication name, strength, and quantity into a log. (E) A licensed nurse places identification information on the medication or package containing the medication that includes the medical care provider ' s name; the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider ' s order. Staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches the information on the medical care provider ' s order. (F) A licensed nurse informs the resident or the resident ' s legal representative that the	S5314		

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S5314	Continued From page 20 medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies. The resident ' s clinical record shall contain documentation that the resident or resident ' s legal representative has received the information and accepted the risk of potential adverse consequences. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(4)(A)(B)(C)(D)(E)(F) The facility reported a census of 6 residents. The sample included 3 residents. Based on interview and observation for 1 (#105) non-sampled resident, the only resident receiving sample medications, the administrator failed to ensure the development of a policy and implementation of the procedure for receiving and identifying sample medications that included all of the following conditions: the medication was not a controlled medication; a medical care provider's written order accompanied the medication, stating the resident's name, the medication name, strength, dosage, route, frequency of administration, and any cautionary instructions regarding administration; a licensed nurse or medication aide received the medication in its original, unbroken manufacturer's package; a licensed nurse documented receipt of the medication by entering the resident's name and the medication name, strength, and quantity into a log; a licensed nurse placed identification information on the medication or package containing the medication that included the medical care provider's name, the resident's	S5314		

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S5314	Continued From page 21 name, the medication name, strength, dosage, route, frequency of administration, and any cautionary instructions as documented on the medical care provider's order; verification by two licensed nurses or a licensed nurse and a medication aide that the information on the medication matched the information on the medical care provider's order; and a licensed nurse informed the resident or the resident's legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which required the identification of both adverse drug interactions or reactions and potential allergies with documentation in the resident's clinical record that the resident or the resident's legal representative received the information and accepted the risk of potential adverse consequences. Findings included: - At 10:20 a.m. on 7/29/15, licensed nurse #A stated (resident #105) received sample medications of Xarelto (for stroke prevention) and Symbicort (to treat chronic obstructive pulmonary disease) provided from a medical care provider's office. Observed that the package of each medication lacked identification information that included the medical care provider's name, the resident's name, the medication name, strength, dosage, route, frequency of administration, and any cautionary instructions as documented on the medical care provider's order. At 11:55 a.m. on 7/29/15, the administrator stated the facility did not have a policy and procedure for receiving and identifying sample medications.	S5314		

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S5314	Continued From page 22 The administrator failed to ensure the development of a policy and implementation of the procedure for receiving and identifying sample medications.	S5314		