STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 000	INITIAL COMMENTS The following citations are the result of a Licensure Resurvey at the above named Assisted Living Facility in Auburn, Kansas on 6/10/15, 6/11/15, 6/15/15, and 6/16/15. Complaint #84630 also investigated.	S 000		
S3166 SS=E	26-41-204 (e) Delegation of Duties (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 26-41-204(e) The census equalled 31 the sample included three Residents, one focused review completed. The facility identified three Residents who used insulin and eleven Residents with glucometer checks. The facility identified seven certified medication aides (CMA's) who performed glucometer checks and prepared insulin pens for Resident self injection. Based on observation, reviews of records and interviews, for one of one sampled (#187) and two non sampled who used insulin; for two of three sampled (#187 and #189) and for eight non sampled with glucometer checks; and for three of seven CMA's (#A, #I, and #E), the Operator/Licensed Nurse failed to ensure procedures not included in the nurse aide or medication aide curriculums appropriately	S3166		

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

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S3166	Continued From page 1 delegated to CMA's. Findings included: - By observation on 6/10/15 at 3:15pm in sampled Resident #187's room, CMA #A carried a prepared insulin pen and glucometer into Resident's room. #A administered a glucometer (blood sugar) check to #187, and then positioned the prepared insulin pen for #187 to self inject. Review of record revealed #187 admitted to facility 5/06/15 with diagnoses of Senile dementia, Diabetes II, Hypertension, Orthostatic hypotension, Syncope and collapse, Malignant neoplasm of skin, Muscle atrophy, Dysphagia, and Hallucinations. The current 5/06/15 functional capacity screen (FCS) assessed #187 unable to perform medication and treatment management. The current 5/06/15 negotiated service agreement (NSA) failed to document glucometer testing or who to administer the tests. The current NSA documented "staff to administer all medications as ordered by physician... staff to administer treatments... CMA's to set up insulin as ordered by physician and #187 to self inject... CMA's to set up insulin listed by name: #E, #B, #F, #H, #G. The NSA lacked the name of #A as a CMA authorized through delegation to complete glucometer checks and insulin pen preparation. Review of record revealed #189 admitted to facility 5/29/15 with diagnoses of Diabetes II, Senile dementia, Hypertension, Alzheimer's, Reflux esophagitis, Hypothyroidism, Senile osteoporosis, Anemia, Diverticuli of colon, Presenile depression, and Restless legs. The current 5/29/15 functional capacity screen	S3166		

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S3166	Continued From page 2 (FCS) assessed #189 unable to perform medication and treatment management. The current 5/29/15 negotiated service agreement (NSA) failed to document glucometer testing or who to administer the tests. The current NSA documented staff to administer all medications and treatments... staff to take glucometer check twice daily and report to nurse if outside parameters"... The NSA lacked the names of CMA's authorized through delegation to complete the glucometer checks. By interview on 6/11/15 at 10:55am, Operator/Licensed Nurse stated we do need to add #A to the NSA for insulin pen preparation... he/she has been instructed by the nurse, but I am unable to find the documentation and #A not included in those named on NSA... confirmed the NSA failed to include glucometer testing: frequency, who to do testing, and what steps to follow with test results. On 6/11/15 at 11:26am Operator/Licensed Nurse stated glucometer not on NSA... done four times daily... stated CMA is to notify nurse if blood sugar less than 50 or more than 300 mg/dl... by review of medical record documentation that hasn't been happening... On 6/11/15 at 2:30pm, Operator/License Nurse and Resident Care Coordinator listed the current 11 Residents with glucometer checks, and verified the three employee files that lacked delegation documentation for glucometer checks and insulin pen preparation. The Operator/Licensed Nurse failed to ensure procedures not included in the nurse aide or medication aide curriculums appropriately delegated to all CMA's.	S3166		

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S3171 SS=E	26-41-204 (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 26-41-204(i) The census equalled 31 the sample included three Residents, one focused review completed. Based on reviews of records and interviews, for one of three sampled (#187) and one focused review (#180), the Operator failed to ensure all health care services, including assessments of Residents (#180), and interventions for blood sugar test results (#187), provided by qualified staff in accordance with acceptable standards of practice. Findings included: - Review of record revealed #187 admitted to facility 5/06/15 with diagnoses of Senile dementia, Diabetes II, Hypertension, Orthostatic hypotension, Syncope and collapse, Malignant neoplasm of skin, Muscle atrophy, Dysphagia, and Hallucinations. The current 5/06/15 functional capacity screen (FCS) assessed #187 unable to perform medication and treatment management. The current negotiated service agreement (NSA) documented "staff to administer all medications as ordered by physician... staff to administer treatments... CMA's to set up insulin as ordered by physician and #187 to self inject... CMA's to	S3171		

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S3171	Continued From page 4 set up insulin listed by name: #E, #B, #F, #H, #G. The current 5/06/15 NSA failed to document glucometer testing, how often testing to be completed, who to administer the tests, and what interventions to follow in accordance with results received. The May 2015 and June 2015 medication administration record (MAR) and June Physician Order Sheet contained a physician's order for glucometer testing completed four times daily... directed "notify nurse if <50 or >300" By review of glucometer test results, blood glucose levels above 300 on multiple occasions: 5/20/15 - 19:41 - 304 5/24/15 - 0600 - 357 5/28/15 - 20:42 - 344 5/29/15 - 21:28 - 383 5/31/15 - 11:26 - 345 Medical record and MAR documentation lacked evidence nurse or physician notified when these readings obtained. By interview on 6/11/15 at 11:26am, Operator/Licensed Nurse confirmed no documentation available to indicate CMA's notified the nurse when blood sugar recorded over 300... confirmed the NSA lacked these services as well. Review of competency checklist used for delegation of glucometer testing to Certified Medication Aides (CMA's) contained the checked skill: "If results are outside of set parameters for the Resident, immediately notify the nurse." The Operator failed to ensure all health care services, including ordered interventions in response to glucose readings outside designated parameters, provided to #187 by qualified staff in accordance with acceptable standards of	S3171		

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S3171	Continued From page 5 practice. - Review of record revealed #180 admitted to facility 4/15/11 with diagnoses of Chronic airway obstruction, Hypertension, Depressive disorder, Anemia, Osteoarthrosis, Reflux esophagitis, and Joint disorder. The previous functional capacity screen (FCS) of 8/30/13 assessed #180 in need of physical assistance with bathing; in need of supervision with dressing; independent with toileting, transfers, walking/mobility, eating, and medication management; unable to perform treatment management; usually continent; with short term memory and memory recall impairments; with falls/unsteadiness and used a walker. The previous negotiated service agreement (NSA) documented staff to assist with bathing, staff supervision with dressing and toileting; independent with transfers, mobility, and with eating; staff to administer all medications and treatments as ordered by physician. This NSA contained a hand written amendment in section "3. Toileting: "3/02/14 staff to toilet Resident upon waking, before and after meals, at bedtime, and as needed." The current 9/16/14 functional capacity screen (FCS) assessed #180 in need of physical assistance with bathing; in need of supervision with dressing, toileting, transfers, walking/mobility; independent with eating; unable to perform medication and treatment management; frequently incontinent; with short term memory and memory recall impairment; with socially inappropriate behavior; used a walker.	S3171		

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The current 9/16/14 NSA documented staff to assist with bathing, supervision with dressing, toileting, transfers, mobility, independent with eating; and treatments as order by physician. This NSA did not include the 3/02/14 intervention to assist #180 with toileting.

By interview on 6/11/15 at 2:15pm Operator/Licensed Nurse stated not sure why we didn't carry over the intervention to assist #180 to the bathroom... we may have re-assessed him/her and decided it wasn't needed...

Review of medical record Clinical Notes revealed:

Note entered 01/07/15 at 11:28am - On 01/05/15 at 7:10pm - CMA (certified medication aide) notified on call nurse #180 observed sitting on floor... per Resident lost balance returning from the bathroom... had no complaint of pain at this time... Resident was oriented... was able to move all upper extremities without complaints... no apparent injuries noted... assisted to feet 2:1... assist with walker... able to bear weight without any complaints... family and physician were notified...

The medical record failed to document a specific licensed nurse assessment at the time of the fall and failed to document any follow up assessment by a licensed nurse.

The next entry in the Clinical Notes described an additional fall entered into the record on 01/08/15 at 2:46pm:
"On 01/07/15 at 6:03pm CMA notified this writer that Resident was heard yelling from her room from the commons area... lying on back on floor... per Resident walker jerked to one side and lost balance and fell... complained of pain in hip/groin

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S3171	Continued From page 7 area... transported to hospital... By interview on 6/11/15 at 2:00pm Operator/Licensed Nurse stated our nurses on call sometimes do assessment on the phone when staff call them... also do vital sign follow up, etc for 72 hours after a fall... in this instance I am not able to find any Nurses' notes or follow up assessments from the 01/05/15 fall... the vital signs record I found is incomplete for the 72 hours... not able to find evidence of a licensed nurse assessment. The Operator failed to ensure all health care services, including licensed nurse assessment and follow-up assessment after a fall provided to #180 by qualified staff in accordance with acceptable standards of practice.	S3171		
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.	S3200		

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S3200	Continued From page 8 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The census equalled 31 the sample included three Residents, one focused review completed. six, five current Residents and one discharged Resident, with one focused review completed. The facility identified all Residents as receiving medication management. Based on reviews of records and interviews, for one of three sampled (#187) the Operator failed to ensure all medications administered to Residents in accordance with a medical care provider's written order and in accordance with professional standards of practice. Findings included: - Review of record revealed #187 admitted to facility 5/06/15 with diagnoses of Senile dementia, Diabetes II, Hypertension, Orthostatic hypotension, Syncope and collapse, Malignant neoplasm of skin, Muscle atrophy, Dysphagia, and Hallucinations. The current 5/06/15 functional capacity screen (FCS) assessed #187 unable to perform medication and treatment management. The current negotiated service agreement (NSA) documented "staff to administer all medications as ordered by physician... staff to administer all treatments... CMA's to set up insulin as ordered by physician and #187 to self inject... At attempt to compare the current June 2015	S3200		

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medication administration record (MAR) with current signed physician's orders revealed the medical record lacked signed orders for #187's medications and treatments.
The record contained a Fax Physician Order Sheet dated 5/06/15... documented the order "Admit to facility, continue same meds until seen, 2 step PPD test, regular diet." This document lacked a physician's signature.

According to May and June 2015 medication administration records (MAR's), #187 received the following:
Dulcolax suppository PRN (as needed) - bowel stimulant
Acetaminophen tablets PRN - pain reliever
Calcium Antacid daily - calcium supplement
Miralax powder daily - laxative
Metoprolol Succinate twice daily - blood pressure medication
Calcitriol daily - Vitamin D supplement
Vitamin D daily - Vitamin D supplement
Multivitamins with minerals - supplement
Ensure Liquid between meals - supplement
Namenda capsule daily - Alzheimer's medication
Januvia tablet daily - antihyperglycemic
Protonix capsule daily - Gastric acid reducer
Zofran PRN - antiemetic
Senna tablets PRN - laxative
Exelon transdermal patch daily - Alzheimer's medication
Lantus insulin pen - diabetic injection
Amlodipine tablet twice daily - blood pressure medication
Ritalin tablet twice daily - attention deficit hyperactivity therapy
Novolog insulin pen - diabetic injection

On 6/11/15 at 3:00pm Operator/Licensed Nurse and Resident Care Coordinator reviewed medical

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record at length and searched through documents not yet scanned into the electronic medical record... each reported no signed medical care orders available for #187 since admission to facility.

The Operator failed to ensure #187 received all medications and biologicals in accordance with a medical care provider's written order and in accordance with professional standards of practice.

- Review of record revealed #185 admitted to facility 02/05/15 with diagnoses of Parkinson's, High cholesterol, Benign prostatic hypertrophy, Mitral valve disease, and Tricuspid valve disease.

The current 3/20/15 functional capacity screen (FCS) assessed #185 unable to perform medication and treatment management.

The current 3/20/15 Negotiated service agreement (NSA) documented "staff to administer all medications as ordered by physician... staff to administer all treatments...

At attempt to compare the current June 2015 medication administration record (MAR) with current signed physician's orders revealed discrepancies. The electronic printed MAR provided to Surveyor failed to differentiate medications given and medications held on 6/05/15. According to the Operator/Licensed Nurse, several medications were held due to an early morning medical procedure. The printed MAR provided to Surveyor contained "=" for medications administered and "x" for those not given. The Operator/Licensed Nurse reviewed the Electronic MAR accessed on his/her computer

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S3200	Continued From page 11 with the printed MAR provided to Surveyor, and confirmed medications not actually administered were all marked with "=": Ferrous Sulfate 325mg (milligrams) Linzess 145 mcg (micrograms) Stalevo 200mg Finasteride 5mg Dailyvite 3000 By interview on 6/11/15 at 12:00pm, Operator/Licensed Nurse and Resident Care Coordinator each stated not aware of why the printed MAR did not identify held medications differently... able to see on the system which medications were held and the reason. In further review and comparison of signed physician orders with the printed electronic MAR, noted date discrepancies between the original physician's order date and the date printed on the MAR as the "Order Date." In addition, the original physician's order had been modified on the MAR in some cases. Examples of these discrepancies follow: Ferrous Sulfate 325mg daily - Order Date (OD) 02/05/15 Linzess 145mcg daily - OD 02/05/15 Gabapentin 100mg TID (three times daily) - OD 02/05/15 Fish Oil 1000mg daily - OD 02/05/15 Tamsulosin 0.4mg daily - OD 02/05/15 Aspirin enteric coated 325mg daily - OD 02/05/15 Stalevo 200mg four times daily - OD 3/2/15 Exelon 9.5mg/24 hour remove patch daily - OD 3/2/15 Carbidopa-Levodpa 25-100mg 1/2 tablet TID - OD 3/20/15 Finasteride 5mg daily - OD 3/20/15 Dailyvite 3000 daily - OD 3/20/15	S3200		

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S3200	Continued From page 12 Amantadine 100mg give 1/2 tablet twice daily - OD 4/13/15 Exelon 9.5mg/24 hour - OD 5/14/15 Miralax 17 gram dose PRN daily starting 5/14/15 - "OD 4/13/15, REASON TO GIVE: complains of constipation OBSERVE FOR: soft, formed stool within 24 hours REPORT TO NURSE: no stool within 24 hours" (Original order: Miralax 17gm PRN every day) Acetaminophen 650mg PRN every four hours starting 5/14/15 - "OD 4/13/15, REASON TO GIVE: complaints of pain OBSERVE FOR: relief of pain REPORT TO NURSE: no relief or an increase in pain NTE 3000MG/24HR" (Original order: Tylenol 650mg every four hours PRN pain) Immodium caplet 2mg give four times daily starting 5/14/15 - "OD 4/20/15, REASON TO GIVE: complaints of watery stools OBSERVE FOR: stools become soft formed REPORT TO NURSE: stools remain loose and watery (Original order: Immodium 2mg four times daily PRN diarrhea) By interview on 6/11/15 at 12:00pm, Operator/Licensed Nurse and Resident Care Coordinator stated: 1) Order dates did not always match because changes made electronically on the order would reflect the date the change made, not the date the order entered into the system and initiated. 2) Some of the wording of the orders modified or changed electronically outside the facility by corporate consultant Nurses. 3) All orders should have a date of 3/20/15 or later due to a hospital return on that date... in some instances the admission date of 02/05/15 remained on MAR medications more currently ordered 3/20/15 The Operator failed to ensure all medications and	S3200		

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S3200	Continued From page 13 biologicals administered to #185 in accordance with written medical care provider orders, and in accordance with professional standards of practice.	S3200		