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	N028003	A. BUILDING: _____ B. WING _____	03/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF GARDEN CITY	2414 N HENDERSON DR GARDEN CITY, KS 67846

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey and investigation of complaint #81868 of the above assisted living facility on 2/24/15, 2/25/15, 2/26/15, 3/2/15, 3/3/15, and 3/4/15.	S 000		
S3028 SS=F	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	S3028		

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

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S3028	Continued From page 1 KAR 26-41-101(f)(3)(A)(C) The facility reported a census of 33 residents. The sample included 3 residents and 2 residents focus review. Based on record review and interview for 1 (#153) of 2 residents focus review, the operator failed to conduct a thorough investigation of an allegation of exploitation. Based on interview for 1 (#156) non-sampled resident the operator failed to report an allegation of exploitation to the department within 24 hours of the allegation. Based on record review and interview for 1 (#150) of 3 residents sampled, the operator failed to investigate the resident's falls in order to rule out abuse and/or neglect. Findings included: - Record review for resident #153 revealed an admission date of 8/10/12 and diagnoses of asthma and chronic obstructive pulmonary disease. The functional capacity screen dated 1/15/15 indicated the resident required supervision with bathing and dressing; was independent with toileting, transferring, and mobility; was unable to perform management of medications and treatments; experienced impaired short-term memory; and was at risk for falls. The negotiated service agreement/health care service plan (NSA/HCSP) documented the services of stand-by assistance with bathing and dressing since resident could get tangled in oxygen tubing and received housekeeping and laundry services. The NSA/HCSP contained documentation that resident had small amount of cash and credit card to use as needed.	S3028		

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S3028	Continued From page 2 On 12/3/14, the operator reported to the department that a police detective came to the facility to ask how to contact one certain employee and names of employees who worked 11/26/14 through 12/2/14 in regards to thefts of resident property. The completed written investigation faxed to the department on 12/9/14 listed resident #153 as the resident involved. The investigation lacked an interview with or written statement from resident #153 or the resident's family. The written investigation lacked information of the missing property of the resident and the outcome of the investigation. Review of the police report related to resident #153's missing property revealed documentation that a family member on 11/3/14 reported a theft of the resident's money. The family member explained that after a theft of resident #153's money in the spring of 2014, the family placed a camera in the resident's room at the facility. Family member reviewed the recording and observed employee #B at approximately 2:00 p.m. on 10/22/14 going to the resident's closet finding the resident's purse, searching through the purse, and sticking something in pocket. The recording showed the employee looking around the room, looking under the mattress, searching drawers, and looking in cabinets. The police report included documentation of an interview with employee #B on 12/3/14 at 11:14 a.m. during which employee #B admitted to taking $22.00 from the resident's purse. The interview included employee #B being informed of resident missing a necklace valued at approximately $10,000. Employee #B denied taking the necklace. The police report included a written statement by employee #B that he/she did take $22.00 from	S3028		

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S3028	Continued From page 3	S3028		

the resident's purse but did not have any idea why or who would have taken the necklace.

The completed written investigation faxed to the department on 12/9/14 listed employee #B suspended from 12/3/14 to 12/7/14.

During a phone interview at 2:12 p.m. on 3/2/15, the operator stated that he/she did not follow-up with the detective in the facility's investigation of the resident's missing property.

The operator failed to conduct a thorough investigation of an allegation of exploitation of resident #153.

- At 10:15 a.m. on 2/26/15, certified nursing assistant #C stated resident (#156) was missing a ring.

During a phone interview at 1:00 p.m. on 3/2/15, the operator stated a family member reported on 2/23/15 that the resident was missing a ring. Operator stated he/she was doing a "thorough check" to find the ring. Operator stated he/she did not report the allegation of exploitation to the department.

The operator failed to report an allegation of exploitation of resident #156 to the department within 24 hours of the allegation.

- Record review for resident #150 revealed an admission date of 8/18/12 and diagnoses of diabetes type II, dementia, and stroke.

The record contained the following functional capacity screens (FCS):

FCS dated 8/1/14, documented as an annual

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S3028	Continued From page 4	S3028		

screen, indicated the resident was independent with transferring and mobility; required physical assistance with bathing, dressing, and toileting; experienced impaired short-term memory and decision making; required a walker or wheelchair for mobility; and was at risk for falls.

FCS dated 12/17/14, documented as a re-admission screen, indicated the resident required supervision with transferring and mobility; required physical assistance with bathing, dressing, and toileting; experienced impaired short-term memory and decision making; required a walker or wheelchair for mobility; and was at risk for falls.

FCS dated 2/19/15, documented as a re-admission screen, indicated the resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; experienced impaired short-term memory, decision making, and memory recall; required a walker or wheelchair for mobility; and was at risk for falls.

The record contained the following negotiated service agreements and health care service plans (NSA/HCSP):

NSA/HCSP dated 8/1/14 documented the services of physical assistance with bathing, dressing, and toileting, The NSA/HCSP lacked health care services related to the resident's risk for falls.

NSA/HCSP dated 12/17/14, documented the services of physical assistance with bathing, dressing, and toileting; cueing and supervision for safe transfers; staff to provide cueing and direction for safety with mobility and mobility per

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S3028	Continued From page 5	S3028		

wheelchair as needed. The NSA/HCSP lacked health care services related to the resident's risk for falls.

NSA/HCSP dated 2/19/15, documented the services of physical assistance with bathing, dressing, and toileting; physical assistance of 1 to 2 staff member to transfer; and physical assistance of 1 to possibly 2 people to ambulate and mobility per wheelchair as needed. The NSA/HCSP contained documentation in the behavior section that resident's family had contacted a long-term care facility with a dementia unit with arrangements being made for resident's transfer as resident's needs can no longer be met in this facility. The NSA/HCSP lacked health care services related to the resident's risk for falls.

The record contained fall risk assessments completed by the licensed nurse/RCC on 12/26/14 and 1/20/15. Each assessment contained a score of 22. The assessment form documented that a score of greater than or equal to 10 indicated a high risk for falls and a care plan with interventions was to be completed related to resident's risk for falls.

Clinical notes contained the following documentation by the licensed nurse/resident care coordinator (RCC) of resident falls:

7/30/14 at 11:00 a.m. staff found resident on the bathroom floor after toileting self. Nurse documented resident had a bruise over lower right buttock and hip and did not want to bear weight on left side. Resident went to hospital and returned. No diagnosis of fracture.

8/11/14 staff found resident at 12:00 p.m. on floor

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of room in sitting position, no injury, and noted to still be confused.

8/20/14 staff found resident on floor by recliner at 11:00 p.m. Resident had apparently crawled out of recliner as the foot rest was up.

8/31/14 staff found resident lying over coffee table that was positioned between recliner and air conditioner unit. Resident's walker was in bathroom. Resident stated was trying to use the restroom.

9/30/14 staff assisted resident to bathroom and when resident pushed call button, staff found resident on floor in room by dining table.

10/15/14 resident called for assistance at 5:50 a.m. Staff found resident on floor on right side and resident complained of hip pain. Resident transported to hospital and returned with diagnosis of bruised right hip and ribs. Resident to use a walker with two wheels instead of walker with 4 wheels.

10/25/14 at 5:00 a.m. staff found resident on floor in room and resident stated he/she slid out of chair. Resident had access to call light but did not use.

11/14/14 resident called for help at 9:00 a.m. and was found sitting on floor in front of sofa. Resident's walker was in the bathroom.

11/18/14 at 5:30 p.m. staff found resident on floor by doorway to room with pants around ankles and walker was in bathroom. Staff had reminded resident to come to supper 15 minutes earlier.

11/27/14 prior to 4:00 p.m. staff found resident in

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S3028	Continued From page 7	S3028		

a semi-seated position with pants down around ankles and wedged between toilet and vanity in resident's bathroom. Resident had urinated on floor and had stuffed toilet paper in sink with water running onto floor of bathroom.

12/2/14 at 11:20 p.m. resident called for help and staff found resident on floor by recliner. Staff had been in resident's room 15 minutes earlier and resident was in recliner with eyes closed. Resident to be admitted to hospital for a geriatric psychological evaluation on 12/4/14.

12/25/14 at 4:40 a.m. staff found resident on floor of room with pajama pants pulled half-way down. Staff had assisted resident with toileting at 4:15 a.m.

12/26/14 at approximately 9:10 p.m. staff found resident on floor by recliner. Staff checked on resident one hour earlier and resident was in recliner.

12/29/14 at 11:10 a.m. resident called for help and staff found resident on floor in front of sofa with walker close by. Resident stated he/she was reaching for a tissue and fell.

1/19/15 at 2:30 a.m. staff found resident on floor in front of recliner. Resident was talking into remote as if talking into a telephone. Resident refused to get up from floor. Resident transferred to hospital per ambulance and returned to facility with diagnosis of dementia.

1/23/15 certified medication aide called licensed nurse/RCC at 7:15 a.m. to report resident was found on bathroom floor with walker on top of resident. Resident received a quarter size skin tear to posterior right forearm.

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S3028	Continued From page 8 2/1/15 staff found resident on floor on back with walker beside resident at 7:20 a.m. Staff had assisted resident with toileting at 6:00 a.m. 2/2/15 staff found resident face down on floor with walker beside resident at 3:00 a.m. Resident had abrasions to both knees. Staff had checked on resident between 2:30 a.m. and 2:45 a.m. Resident's blood sugar was 58 and licensed nurse/RCC instructed staff to give resident milk, peanut butter, or cheese to eat and assist resident to recliner. During a phone interview at 1:05 p.m. on 3/2/15, the licensed nurse/RCC stated he/she did not report to the department or investigate the resident's falls to rule out resident abuse or neglect. The operator failed to investigate resident #150's falls in order to rule out abuse and/or neglect.	S3028		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a)	S3155		

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S3155	Continued From page 9 The facility reported a census of 33 residents. The sample included 3 residents and 2 residents focus review. Based on record review, interview, and observation for 2 (#150 and #151) of 3 residents sampled, the operator failed to ensure the licensed nurse/resident care coordinator (RCC) provided or coordinated necessary health care services that met the needs of each resident identified at risk for falls in accordance with the functional capacity screen and the negotiated service agreement. Findings included: - Record review for resident #150 revealed an admission date of 8/18/12 and diagnoses of diabetes type II, dementia, and stroke. The record contained the following functional capacity screens (FCS): FCS dated 8/1/14, documented as an annual screen, indicated the resident was independent with transferring and mobility; required physical assistance with bathing, dressing, and toileting; experienced impaired short-term memory and decision making; required a walker or wheelchair for mobility; and was at risk for falls. FCS dated 12/17/14, documented as a re-admission screen, indicated the resident required supervision with transferring and mobility; required physical assistance with bathing, dressing, and toileting; experienced impaired short-term memory and decision making; required a walker or wheelchair for mobility; and was at risk for falls. FCS dated 2/19/15, documented as a	S3155		

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S3155	Continued From page 10	S3155		

re-admission screen, indicated the resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; experienced impaired short-term memory, decision making, and memory recall; required a walker or wheelchair for mobility; and was at risk for falls.

The record contained the following negotiated service agreements and health care service plans (NSA/HCSP):

NSA/HCSP dated 8/1/14 documented the services of physical assistance with bathing, dressing, and toileting, The NSA/HCSP lacked health care services related to the resident's risk for falls.

NSA/HCSP dated 12/17/14, documented the services of physical assistance with bathing, dressing, and toileting; cueing and supervision for safe transfers; staff to provide cueing and direction for safety with mobility and mobility per wheelchair as needed. The NSA/HCSP lacked health care services related to the resident's risk for falls.

NSA/HCSP dated 2/19/15, documented the services of physical assistance with bathing, dressing, and toileting; physical assistance of 1 to 2 staff member to transfer; and physical assistance of 1 to possibly 2 people to ambulate and mobility per wheelchair as needed. The NSA/HCSP contained documentation in the behavior section that resident's family had contacted a long-term care facility with a dementia unit with arrangements being made for resident's transfer as resident's needs can no longer be met in this facility. The NSA/HCSP lacked health care services related to the

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resident's risk for falls.

The record contained fall risk assessments completed by the licensed nurse/RCC on 12/26/14 and 1/20/15. Each assessment contained a score of 22. The assessment form documented that a score of greater than or equal to 10 indicated a high risk for falls and a care plan with interventions was to be completed related to resident's risk for falls.

Clinical notes contained the following documentation by the licensed nurse/RCC of resident falls:

7/30/14 at 11:00 a.m. staff found resident on the bathroom floor after toileting self. Nurse documented resident had a bruise over lower right buttock and hip and did not want to bear weight on left side. Resident went to hospital and returned. No diagnosis of fracture.

8/11/14 staff found resident at 12:00 p.m. on floor of room in sitting position, no injury, and noted to still be confused.

8/20/14 staff found resident on floor by recliner at 11:00 p.m. Resident had apparently crawled out of recliner as the foot rest was up.

8/31/14 staff found resident lying over coffee table that was positioned between recliner and air conditioner unit. Resident's walker was in bathroom. Resident stated was trying to use the restroom.

9/30/14 staff assisted resident to bathroom and when resident pushed call button, staff found resident on floor in room by dining table.

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S3155	Continued From page 12 10/15/14 resident called for assistance at 5:50 a.m. Staff found resident on floor on right side and resident complained of hip pain. Resident transported to hospital and returned with diagnosis of bruised right hip and ribs. Resident to use a walker with two wheels instead of walker with 4 wheels. 10/25/14 at 5:00 a.m. staff found resident on floor in room and resident stated he/she slid out of chair. Resident had access to call light but did not use. 11/14/14 resident called for help at 9:00 a.m. and was found sitting on floor in front of sofa. Resident's walker was in the bathroom. 11/18/14 at 5:30 p.m. staff found resident on floor by doorway to room with pants around ankles and walker was in bathroom. Staff had reminded resident to come to supper 15 minutes earlier. 11/27/14 prior to 4:00 p.m. staff found resident in a semi-seated position with pants down around ankles and wedged between toilet and vanity in resident's bathroom. Resident had urinated on floor and had stuffed toilet paper in sink with water running onto floor of bathroom. 12/2/14 at 11:20 p.m. resident called for help and staff found resident on floor by recliner. Staff had been in resident's room 15 minutes earlier and resident was in recliner with eyes closed. Resident to be admitted to hospital for a geriatric psychological evaluation on 12/4/14. 12/25/14 at 4:40 a.m. staff found resident on floor of room with pajama pants pulled half-way down. Staff had assisted resident with toileting at 4:15 a.m.	S3155		

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S3155	Continued From page 13 12/26/14 at approximately 9:10 p.m. staff found resident on floor by recliner. Staff checked on resident one hour earlier and resident was in recliner. 12/29/14 at 11:10 a.m. resident called for help and staff found resident on floor in front of sofa with walker close by. Resident stated he/she was reaching for a tissue and fell. 1/19/15 at 2:30 a.m. staff found resident on floor in front of recliner. Resident was talking into remote as if talking into a telephone. Resident refused to get up from floor. Resident transferred to hospital per ambulance and returned to facility with diagnosis of dementia. 1/23/15 certified medication aide called licensed nurse/RCC at 7:15 a.m. to report resident was found on bathroom floor with walker on top of resident. Resident received a quarter size skin tear to posterior right forearm. 2/1/15 staff found resident on floor on back with walker beside resident at 7:20 a.m. Staff had assisted resident with toileting at 6:00 a.m. 2/2/15 staff found resident face down on floor with walker beside resident at 3:00 a.m. Resident had abrasions to both knees. Staff had checked on resident between 2:30 a.m. and 2:45 a.m. Resident's blood sugar was 58 and licensed nurse/RCC instructed staff to give resident milk, peanut butter, or cheese to eat and assist resident to recliner. On 2/2/15, the licensed nurse/RCC documented the executive director (operator) and licensed nurse (RCC) met with the resident's family to	S3155		

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S3155	Continued From page 14 discuss the resident's frequent falls with family aware of possible need to admit resident to a facility for higher level of care due to frequent falls and unpredictable behaviors. On 2/4/15, licensed nurse/RCC documented resident admitted to hospital for re-evaluation of medications and behaviors. Resident returned to the facility on 2/19/15 and licensed nurse/RCC documented resident walked with a shuffling gait, placed walker too far in front of him/her, and did not seem to understand when instructed to stand up straight when walking. The record contained documentation by the corporate nurse dated 1/26/15 of discussion of resident ' s frequent falls with the operator and licensed nurse/RCC. Corporate nurse documented he/she suggested the operator and licensed nurse/RCC visit with the resident's family of possibility of a private sitter for resident. The record contained a managed risk agreement dated 1/29/15 and signed by the resident's family member, the operator, and the licensed nurse/RCC that documented the following: Family prefers resident remain in this facility as long as possible as resident has adjusted to this environment. Possible consequences: Falls with serious injuries, including broken bones, possible death, and subdural hematoma. Alternatives offered to minimize risk: Resident instructed to use call light and wait for assistance with transfers, reminders posted in room to use call light, and discussed private duty companion as option. Interviewed resident #150 at 10:35 a.m. on	S3155		

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2/26/15 in the resident's room. Resident stood with one hand on walker and the other hand on the rail on the side of the bed and slowly turned self to sit on edge of bed. Observed the recliner with the foot rest up. Resident stated he/she crawled in and out of recliner. Resident confirmed he/she had fallen several times and attributed falls to having had 2 strokes.

During an interview at 1:30 p.m. on 2/26/15, the licensed nurse/RCC stated staff could not manage the resident's falls without someone with resident all the time. Licensed nurse/RCC stated that instructing staff to check on resident every 30 minutes at night and keeping resident in commons area during the day was "the best we can do."

The operator failed to ensure the licensed nurse/RCC provided or coordinated necessary health care services that met the needs of resident #150, who was identified at risk for falls, in accordance with the functional capacity screen and the negotiated service agreement.

- Record review for resident #151 revealed an admission date of 9/15/14 and diagnoses of dementia, atrial fibrillation, and hypertension.

The functional capacity screen dated 9/15/14 indicated the resident required supervision with bathing and transferring; was independent with dressing, toileting, and mobility; and experienced impaired short-term memory. The functional capacity screen indicated the resident was not at risk for falls.

The negotiated service agreement/health care service plan (NSA/HCSP) dated 9/15/14 documented the services of assistance in and out

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S3155	Continued From page 16	S3155		

of shower, assistance with transfers as requested by resident due to weakness, and mobilizes self in wheelchair.

The record contained a fall risk assessment completed by the licensed nurse/RCC on 11/28/14 with a score of 12. The assessment form documented that a score of greater than or equal to 10 indicated a high risk for falls and a care plan with interventions was to be completed related to resident's risk for falls.

Clinical notes contained the following documentation by the licensed nurse/RCC of resident falls:

9/26/14 at 11:15 p.m. staff found resident on floor beside bed. Resident had slid off bed while trying to get in bed. Resident was wearing silky pajamas.

9/29/14 at 7:00 a.m. resident slid off bed when getting out of bed.

10/6/14 in the morning, resident called for help and was found lying on the floor on right side. Wheelchair was tipped over by the bed. Resident stated fell when getting out of bed.

10/30/14 staff entered room and found resident on floor in bathroom. Requested order for physical therapy from medical care provider.

11/28/14 at 1:30 a.m. resident called for help and staff found resident sitting on floor on the foot pedals of wheelchair. The wheelchair tipped over. Resident was wearing silky pajamas and barefooted. Resident stated he/she was going to go into the bathroom when he/she fell. Staff assisted resident to the bathroom. Licensed

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S3155	Continued From page 17 nurse/RCC called family member to provide resident with different pajamas that are not silky. Remove leg extensions from wheelchair to avoid obstruction when resident transfers self to wheelchair. 12/14/14 at 1:30 a.m. staff called licensed nurse/RCC to report resident was on floor between closet and bed. Resident fell when trying to pick an object up from floor. Grabber device found in closet and given to resident to use to pick up objects from floor. 2/2/15 at 11:30 a.m. resident called for assistance due to fall from motorized wheelchair when trying to get something from refrigerator. Resident had bitten tongue and complained of neck pain. Motorized wheelchair missing a foot rest and instructed resident to not use motorized wheelchair until a foot rest obtained. The functional capacity screen and NSA/HCSP lacked revision following the resident's multiple falls. At 1:25 p.m. on 2/26/15, the licensed nurse/RCC confirmed the resident was at risk for falls and NSA/HCSP lacked interventions related to the resident's risk for falls. The operator failed to ensure the licensed nurse/RCC provided or coordinated necessary health care services that met the needs of resident #151 who was identified at risk for falls.	S3155		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s	S3200		

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S3200	Continued From page 18 medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility reported a census of 33 residents. The sample included 3 residents and 2 residents focus reviewed. Based on record review and interview for 1 (#150) of 1 resident requiring insulin injections, the operator failed to ensure the resident received insulin in accordance with professional standards of practice. Findings included: - Record review for resident #150 revealed an admission date of 8/18/12 and diagnoses of type II diabetes mellitus, dementia, and stroke. The functional capacity screen dated 2/19/15 indicated the resident was unable to perform medication management and experienced	S3200		

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S3200	Continued From page 19 impaired short-term memory, decision making, and memory recall. The negotiated service agreement/health care service plan dated 2/19/15 documented the service of certified medication aide to put needle on insulin pen, prime, dial dose, and hand pen to resident to self-inject insulin. During an interview at 1:20 p.m. on 2/25/15, certified medication aide #stated resident self-injected insulin with an insulin pen prepared and dialed by a certified medication aide. The resident's record lacked documentation of an assessment by a licensed nurse that resident was able to inject insulin with an insulin pen prepared and dialed by a certified medication aide. At 11:55 a.m. on 2/26/15, licensed nurse/resident care coordinator (RCC) provided an assessment by a licensed nurse dated 8/21/12 with review of resident's ability to self-inject insulin on 12/10/12 and 3/22/13. Licensed nurse/RCC stated he/she had not assessed the resident's ability to inject insulin with an insulin pen prepared and dialed by a certified medication aide. The operator failed to ensure resident #150 received insulin in accordance with professional standards of practice.	S3200		
S3214 SS=F	26-41-205 (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	S3214		

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S3214	Continued From page 20 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. Facility 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 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	S3214		

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S3214	Continued From page 21 clinical record shall contain documentation that the resident or the 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 26-41-205(g)(4)(A)(B)(C)(D)(E)(F) The facility reported a census of 33 residents. The sample included 3 residents and 2 residents focus reviewed. Based on interview and observation for 1(#155) non-sampled resident receiving a sample medication supplied by a medical care provider, the operator 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 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	S3214		

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S3214	Continued From page 22	S3214		

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 1:20 p.m. on 2/25/15, certified medication aide (CMA) #A removed a package of Abilify (antipsychotic) 2 milligram tablets from a drawer in the medication cart. The package contained the first name and initial of the last name of resident #155. CMA #A stated the resident received the medication supply from the medical care provider and not from a pharmacy. CMA #A stated the nurse wrote the resident's name on the package along with the licensed nurse's initials and date resident brought the medication to the facility. CMA #A stated resident (#155) was the only resident in the facility who received a sample medication.

At 5:30 p.m. on 2/25/15, licensed nurse/resident care coordinator stated the facility did not have a policy and procedure for the receipt and identification of sample medications.

For resident #155, the operator failed to ensure

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S3214	Continued From page 23 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 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.	S3214		