STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087119	A. BUILDING: _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING BY WARDEN LLC	234 S ANNA ST WICHITA, KS 67209

(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 1/5/15, 1/6/15, 1/7/15, and 1/8/15.	S 000		
S5116 SS=D	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement 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; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(2) The facility reported a census of 9 residents. The sample included 3 residents and 1 focus review resident. Based on record review, observation, and interview for 1 (#110) of 3 residents sampled, the administrator failed to ensure the revision of the negotiated service agreement when the resident experienced a significant change in condition. Findings included: - Record review for resident #110 revealed an	S5116		

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

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S5116	Continued From page 1 admission date of 4/29/13 and diagnosis of dementia. The functional capacity screen dated 4/11/14 indicated the resident required physical assistance with eating; was unable to perform bathing, dressing, toileting, transferring, mobility, and management of medications and medical treatments; was occasionally incontinent of urine; experienced impaired short-term memory, long-term memory, decision-making, and memory recall; impaired ability to communicate and understand communication; was at risk for falls; and utilized a wheelchair for mobility. The negotiated service agreement (NSA) dated 4/29/13 with review on 4/11/14 listed hospice as an outside provider with start of care date 4/25/13. The NSA documented hospice provided skilled nursing services and bathing assistance 3 times a week. The NSA documented that hospice provided payment of the resident's medications and incontinence supplies. The NSA contained food service of a pureed diet with staff providing feeding assistance. The record contained hospice documentation that hospice services were discontinued 11/26/14. The physician order sheet signed by the medical care provider on 9/25/14 contained an order for a regular mechanical soft diet. At 12:45 p.m. on 1/5/15, observed certified medication aide (CMA) #C feeding resident. CMA #C stated meal was chicken scampi, pea pods, and yogurt. Observed chunks of chicken in noodles and whole pea pods. The chicken and pea pods were not ground or mechanically altered in order to follow the prescribed diet.	S5116		

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S5116	Continued From page 2 During an interview at 10:40 a.m. on 1/6/15, certified nursing assistant #F stated facility certified employees provided bathing assistance to resident and confirmed resident was on a mechanical soft diet. At 1:35 p.m. on 1/6/15, licensed nurse #D stated hospice services were discontinued and resident required mechanical soft diet. Licensed nurse #D confirmed the negotiated service agreement was not revised to reflect the change in services and provider of services. The administrator failed to ensure the revision of the negotiated service agreement for resident #110 when the resident experienced a significant change in condition.	S5116		
S5165 SS=F	26-42-204 (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 26-42-204(e) The facility reported a census of 9 residents. The sample included 3 residents and 1 focus review resident. Based on record review, interview, and observation for 1 (#111) of 3 residents sampled and 1 (#113) focus review resident, the licensed nurse failed to delegate glucometer blood sugar testing to certified medication aides, under the	S5165		

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S5165	Continued From page 3 Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included: - Record review for resident #111 revealed an admission date of 12/28/12 and diagnoses of diabetes mellitus type II and Alzheimer's disease. The functional capacity screen dated 3/3/14 indicated the resident was unable to perform management of medications and medical treatments. The negotiated service agreement dated 3/10/14 documented (licensed nurse) supervised service of finger-stick for blood sugar level. Focus record review for resident #113 revealed an admission date of 7/3/13 and diagnosis of diabetes mellitus type II. The functional capacity screen dated 7/2/14 indicated the resident was unable to perform management of medications and treatments. The negotiated service agreement dated 7/25/14 documented (licensed nurse) supervised service of finger-stick for blood sugar level. The 12/1/14 through 12/31/14 medication administration record contained documentation that the resident received Novolog insulin according to sliding scale dose of 2 units for blood sugar level of 200 to 250, 4 units for blood sugar level 251 to 300, 6 units for blood sugar level 301 to 350 and call medical care provider if level greater than 350. Review of the 12/1/14 through 12/31/14 documentation of blood sugar levels revealed the resident received the following extra doses of Novolog due to elevated blood sugar determined by the results of glucometer testing by certified medication aides: 12/2/14 at 11:00 a.m. 2 units for blood sugar level of 248	S5165		

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S5165	Continued From page 4 12/2/14 at 3:00 p.m. 4 units for blood sugar of 277 12/4/14 at 8:00 p.m. 2 units for blood sugar of 244 12/12/14at 6:00 a.m. 2 units for blood sugar of 242 12/12/14 at 3:30 p.m. 4 units for blood sugar of 267 12/12/14 at 8:30 p.m. 2 units for blood sugar of 245 12/13/14 at 11:35 a.m. 5 units for blood sugar of 360, nurse notified 12/13/14 at 3:00 p.m. 2 units for blood sugar of 223 12/13/14 at 8:00 p.m. 4 units for blood sugar of 258 12/14/14 at 3:00 p.m. 4 units for blood sugar of 283 12/14/14 at 8:00 p.m. 2 units for blood sugar of 237 12/17/14 at 3:00 p.m. 4 units for blood sugar of 283 12/18/14 at 11:00 a.m. 6 units for blood sugar of 320 12/18/14 at 3:30 p.m. 4 units for blood sugar of 266 12/18/14 at 8:00 p.m. 2 units for blood sugar of 249 12/21/14 at 11:00 a.m. 2 units for blood sugar 243 12/21/14 at 3:00 p.m. 2 units for blood sugar of 202 12/24/14 at 11:00 a.m. 4 units for blood sugar of 272 12/25/14 at 8:00 p.m. 4 units for blood sugar of 254 12/26/14 at 12:00 p.m. 2 units for blood sugar of 234 12/26/14 at 8:00 p.m. 2 units for blood sugar of 228 12/28/14 at 12:00 p.m. 2 units for blood sugar of	S5165		

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S5165	Continued From page 5 239 At 3:00 p.m. on 1/5/15, observed certified medication aide (CMA) #A prick the finger of resident #113 to obtain a blood sample to test the resident's blood sugar with a glucometer. At 3:15 p.m. on 1/5/15, observed CMA #B prick the finger of resident #111 to obtain a blood sample to test the resident's blood sugar with a glucometer. Review of employee files at 11:15 a.m. on 1/6/15 revealed the file of CMA #A lacked documentation that the licensed nurse delegated glucometer testing of blood sugar to the CMA and documentation of the CMA's competency to perform the procedure. At 11:25 a.m. on 1/6/15, licensed nurse #D stated he/she trained CMAs to use a glucometer to test resident blood sugar level but did not document each CMA's competency to perform the procedure. The licensed nurse failed to delegate glucometer blood sugar testing to certified medication aides, 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	S5171		

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S5171	Continued From page 6 by: KAR 26-42-204(i) The facility reported a census of 9 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 3 (#111, #112, and #113) of 3 residents requiring insulin injections, the administrator failed to ensure all health care services were provided to residents by qualified staff in accordance with acceptable standards of practice. Findings included: - Review of the resident roster completed by licensed nurse #D at 11:45 a.m. on 1/5/15 revealed no resident required insulin injections. Record review for resident #111 revealed an admission date of 12/28/12 and diagnoses of diabetes mellitus type II and Alzheimer's disease. The functional capacity screen dated 3/3/14 indicated the resident was unable to perform management of medication and experienced impaired short-term and long-term memory, decision making, and memory recall. The negotiated service agreement dated 3/10/14 documented the service of facility management of medications. The 12/1/14 through 12/31/14 medication administration record contained documentation that the resident received Novolog (insulin) 12 units subcutaneously with each meal for type II diabetes and Lantus (insulin) 16 units at 8:00 p.m. Insulin is an injectable medication. Only licensed nurses can administer injectable medications. Record review for resident #112 revealed an admission date of 6/21/13 and diagnosis of	S5171		

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S5171	Continued From page 7 diabetes mellitus type II. The functional capacity screen dated 6/10/14 indicated the resident was unable to perform management of medication and experienced impaired short-term memory, decision making, and memory recall. The negotiated service agreement dated 6/26/13 and reviewed 6/10/14 documented the service of facility management of medications. The 12/1/14 through 12/31/14 medication administration record contained documentation that the resident received Lantus (insulin) 12 units subcutaneously every evening at 5:00 p.m. Insulin is an injectable medication. Only licensed nurses can administer injectable medications. Record review for resident #113 revealed an admission date of 7/3/13 and diagnosis of diabetes mellitus type II. The functional capacity screen dated 7/2/14 indicated the resident was unable to perform management of medications and experienced impaired short-term and long-term memory, decision making, and memory recall. The negotiated service agreement dated 7/25/14 documented the service of facility management of medications. The 12/1/14 through 12/31/14 medication administration record contained documentation that the resident received Novolog (insulin) 10 units subcutaneously 3 times a day with meals and Novolog insulin according to sliding scale dose of 2 units for blood sugar level of 200 to 250, 4 units for blood sugar level 251 to 300, 6 units for blood sugar level 301 to 350 and call medical care provider if level greater than 350. Review of the 12/1/14 through 12/31/14 documentation of blood sugar levels revealed the resident received the following extra doses of Novolog due to elevated blood sugar: 12/2/14 at 11:00 a.m. 2 units for blood sugar level of 248	S5171		

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S5171	Continued From page 8 12/2/14 at 3:00 p.m. 4 units for blood sugar of 277 12/4/14 at 8:00 p.m. 2 units for blood sugar of 244 12/12/14at 6:00 a.m. 2 units for blood sugar of 242 12/12/14 at 3:30 p.m. 4 units for blood sugar of 267 12/12/14 at 8:30 p.m. 2 units for blood sugar of 245 12/13/14 at 11:35 a.m. 5 units for blood sugar of 360, nurse notified 12/13/14 at 3:00 p.m. 2 units for blood sugar of 223 12/13/14 at 8:00 p.m. 4 units for blood sugar of 258 12/14/14 at 3:00 p.m. 4 units for blood sugar of 283 12/14/14 at 8:00 p.m. 2 units for blood sugar of 237 12/17/14 at 3:00 p.m. 4 units for blood sugar of 283 12/18/14 at 11:00 a.m. 6 units for blood sugar of 320 12/18/14 at 3:30 p.m. 4 units for blood sugar of 266 12/18/14 at 8:00 p.m. 2 units for blood sugar of 249 12/21/14 at 11:00 a.m. 2 units for blood sugar 243 12/21/14 at 3:00 p.m. 2 units for blood sugar of 202 12/24/14 at 11:00 a.m. 4 units for blood sugar of 272 12/25/14 at 8:00 p.m. 4 units for blood sugar of 254 12/26/14 at 12:00 p.m. 2 units for blood sugar of 234 12/26/14 at 8:00 p.m. 2 units for blood sugar of 228 12/28/14 at 12:00 p.m. 2 units for blood sugar of	S5171		

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S5171	Continued From page 9 239 Insusulin is an injectable medication. Only licensed nurses can administer injectable medications. During an interview at 1:05 p.m. on 1/5/15, certified medication aide (CMA) #C stated that he/she administered insulin injections to residents (#111, #112, and #113). CMA #C explained he/she obtained the insulin pen for the resident at the time the resident would receive insulin, applied the needle to the pen, dialed the pen to 2 units to prime the pen, dialed the dose the resident would receive, injected the insulin into the resident, held the end of the pen down for 6 seconds and then removed the pen with the needle from the resident's skin. CMA #C confirmed he/she was not a licensed nurse. During an interview at 2:40 p.m. on 1/5/15, CMA #A stated he/she administered insulin injections to residents (#111, #112, and #113). CMA #A described the same procedure for insulin administration as CMA #C. Licensed nurse #D, present during the interview with CMA #A, stated he/she instructed CMAs on how to administer insulin injections. Licensed nurse #D provided documentation that outlined step-by-step procedure for administration of insulin with insulin pen. The documentation contained the signature of licensed nurse #D and a CMA. At 10:10 a.m. on 1/8/14, licensed nurse #D provided two "Insulin Administration --Employee Competency" forms with step-by-step instructions for preparing the insulin pen and administering the insulin to a resident. One form contained the name of CMA #A and one form contained the	S5171		

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S5171	Continued From page 10 name of CMA #C. Each form documented "Competency achieved" and "Verified by" with signature of licensed nurse #D. For residents #111, #112, and #113, the administrator failed to ensure all health care services were provided to residents by qualified staff in accordance with acceptable standards of practice.	S5171		
S5185 SS=D	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(c) The facility reported a census of 9 residents. The sample included 3 residents and 1 focus review resident. Based on record review, observation, and interview for 1 (#110) of 3 residents sampled, the administrator failed to ensure the provision of	S5185		

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S5185	Continued From page 11 a mechanically altered diet prepared according to instructions from a medical care provider or licensed dietitian Findings included: - Record review for resident #110 revealed an admission date of 4/29/13 and diagnosis of dementia. The functional capacity screen dated 4/11/14 indicated the resident required physical assistance with eating and experienced impaired short-term memory, long-term memory, decision-making, and memory recall. The negotiated service agreement dated 4/29/13 with review on 4/11/14 contained food service of a pureed diet with staff providing feeding assistance. The physician order sheet signed by the medical care provider on 9/25/14 contained an order for a regular mechanical soft diet. At 12:45 p.m. on 1/5/15, observed certified medication aide (CMA) #C feeding resident. CMA #C stated meal was chicken scampi, pea pods, and yogurt. Observed chunks of chicken in noodles and whole pea pods. The chicken and pea pods were not ground or mechanically altered in order to follow the prescribed diet. At 11:00 a.m. on 1/6/15, licensed nurse #D provided a signed medical care provider's order to discontinue pureed diet and change diet to a mechanical soft diet as desired. During an interview at 12:05 p.m. on 1/6/15, the administrator confirmed the lack of instructions	S5185		

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S5185	Continued From page 12 from a medical care provider or licensed dietitian regarding how to prepare a mechanical soft diet. For resident #110, the administrator failed to ensure the provision of a mechanically altered diet prepared according to instructions from a medical care provider or licensed dietitian	S5185		
S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(f) The facility reported a census of 9 residents. The sample included 3 residents and 1 focus review resident. Based on observation and interview for all residents, the administrator failed to ensure staff stored all foods under safe and sanitary conditions. Findings included: - During tour of the facility food storage area at 10:00 a.m. on 1/6/15 observed the following items in the pantry: Tortillas package open without date opened Hot dog buns with "best by" date of 11/24/14 Partial loaf of bread without date opened	S5195		

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S5195	Continued From page 13 Cobblestone bread with "best by" date of 1/3/15 Onion hamburger buns with "best by" date of 12/26/14 Hawaiian rolls with "best by" date of 12/28/14 Cookies in a resealable plastic sandwich bag without a label to identify or a date placed in bag Plastic canister with what appeared to be instant rice without a label to identify or a date when placed in canister. One partial bag of dry noodles without a date opened A plastic resealable bag of nuts without label to identify and date placed in bag Peanut butter without a date opened Dry cereal 3 canisters without a label to identify and date placed in canister Certified medication aide #C stated employees did not date dry foods when opened. Freezer section of the refrigerator/freezer contained frozen chicken breast pieces in an opened resealable plastic bag without a label of the date placed in freezer and the date the package was opened. Refrigerator contained the following items: Metal bowl containing 2 packages of raw partially frozen ground beef, a reasealable plastic bag of pre-cooked sausage links, and a plastic resealable bag of strawberries. The lower left drawer contained numerous plastic resealable plastic bags of leftover food items that lacked a label to identify the food items. Some of the bags were dated and had been in the refrigerator longer than 3 days. At 10:15 a.m. on 1/6/15, the administrator stated the ground beef, sausage, and the strawberries were placed in the metal bowl in the refrigerator to thaw. Administrator stated leftovers were to be	S5195		

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	B087119	A. BUILDING: _____ B. WING _____	01/08/2015

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S5195	Continued From page 14 discarded within 3 days. Administrator stated employees did not date foods when placed in the freezer if not removed from original packaging. For all residents, the administrator failed to ensure staff stored all foods under safe and sanitary conditions.	S5195		
S5300 SS=F	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(2) The facility reported a census of 9 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 3 (#111, #112, and #113) of 3 residents requiring insulin injections, the administrator	S5300		

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S5300	Continued From page 15 failed to ensure certified medication aides did not administer medication through the parenteral (injectable) route. Findings included: - Review of the resident roster completed by licensed nurse #D at 11:45 a.m. on 1/5/15 revealed no resident required insulin injections. Record review for resident #111 revealed an admission date of 12/28/12 and diagnoses of diabetes mellitus type II and Alzheimer's disease. The functional capacity screen dated 3/3/14 indicated the resident was unable to perform management of medication and experienced impaired short-term and long-term memory, decision making, and memory recall. The negotiated service agreement dated 3/10/14 documented the service of facility management of medications. The 12/1/14 through 12/31/14 medication administration record contained documentation that the resident received Novolog (insulin) 12 units subcutaneously with each meal for type II diabetes and Lantus (insulin) 16 units at 8:00 p.m. Insulin is administered subcutaneously which is a parenteral route. Record review for resident #112 revealed an admission date of 6/21/13 and diagnosis of diabetes mellitus type II. The functional capacity screen dated 6/10/14 indicated the resident was unable to perform management of medication and experienced impaired short-term, decision making, and memory recall. The negotiated service agreement dated 6/26/13 and reviewed 6/10/14 documented the service of facility management of medications. The 12/1/14 through 12/31/14 medication administration record contained documentation that the resident	S5300		

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S5300	Continued From page 16	S5300		

received Lantus (insulin) 12 units subcutaneously every evening at 5:00 p.m. Insulin is administered subcutaneously which is a parenteral route.

Record review for resident #113 revealed an admission date of 7/3/13 and diagnosis of diabetes mellitus type II. The functional capacity screen dated 7/2/14 indicated the resident was unable to perform management of medications and experienced impaired short-term and long-term memory, decision making, and memory recall. The negotiated service agreement dated 7/25/14 documented the service of facility management of medications. The 12/1/14 through 12/31/14 medication administration record contained documentation that the resident received Novolog (insulin) 10 units subcutaneously 3 times a day with meals and Novolog insulin according to sliding scale dose of 2 units for blood sugar level of 200 to 250, 4 units for blood sugar level 251 to 300, 6 units for blood sugar level 301 to 350 and call medical care provider if level greater than 350. Review of the 12/1/14 through 12/31/14 documentation of blood sugar levels revealed the resident received the following extra doses of Novolog due to elevated blood sugar:
12/2/14 at 11:00 a.m. 2 units for blood sugar level of 248
12/2/14 at 3:00 p.m. 4 units for blood sugar of 277
12/4/14 at 8:00 p.m. 2 units for blood sugar of 244
12/12/14at 6:00 a.m. 2 units for blood sugar of 242
12/12/14 at 3:30 p.m. 4 units for blood sugar of 267
12/12/14 at 8:30 p.m. 2 units for blood sugar of 245
12/13/14 at 11:35 a.m. 5 units for blood sugar of

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S5300	Continued From page 17 360, nurse notified 12/13/14 at 3:00 p.m. 2 units for blood sugar of 223 12/13/14 at 8:00 p.m. 4 units for blood sugar of 258 12/14/14 at 3:00 p.m. 4 units for blood sugar of 283 12/14/14 at 8:00 p.m. 2 units for blood sugar of 237 12/17/14 at 3:00 p.m. 4 units for blood sugar of 283 12/18/14 at 11:00 a.m. 6 units for blood sugar of 320 12/18/14 at 3:30 p.m. 4 units for blood sugar of 266 12/18/14 at 8:00 p.m. 2 units for blood sugar of 249 12/21/14 at 11:00 a.m. 2 units for blood sugar 243 12/21/14 at 3:00 p.m. 2 units for blood sugar of 202 12/24/14 at 11:00 a.m. 4 units for blood sugar of 272 12/25/14 at 8:00 p.m. 4 units for blood sugar of 254 12/26/14 at 12:00 p.m. 2 units for blood sugar of 234 12/26/14 at 8:00 p.m. 2 units for blood sugar of 228 12/28/14 at 12:00 p.m. 2 units for blood sugar of 239 Insulin is administered subcutaneously which is a parenteral route. During an interview at 1:05 p.m. on 1/5/15, certified medication aide (CMA) #C stated that he/she administered insulin injections to residents (#111, #112, and #113). CMA #C explained he/she obtained the insulin pen for the resident at the time the resident was to receive insulin, applied the needle to the pen, dialed the pen to 2	S5300		

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S5300	Continued From page 18 units to prime the pen, dialed the dose the resident would receive, injected the insulin into the resident, held the end of the pen down for 6 seconds and then removed the pen with the needle from the resident's skin. During an interview at 2:40 p.m. on 1/5/15, CMA #A stated he/she administered insulin injections to residents (#111, #112, and #113). CMA #A described the same procedure for insulin administration as CMA #C. Licensed nurse #D, present during the interview with CMA #A, stated he/she instructed CMAs on how to administer insulin injections. Licensed nurse #D provided documentation that outlined step-by-step procedure for administration of insulin with insulin pen. The documentation contained the signature of licensed nurse #D and a CMA. For residents #111, #112, and #113, the administrator failed to ensure certified medication aides did not administer medication through the parenteral route.	S5300		
S5313 SS=F	26-42-205 (g) (3) Over the counter medication (g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the	S5313		

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S5313	Continued From page 19 original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(3) The facility reported a census of 9 residents. The sample included 3 residents and 1 focus review resident. Based on record review, observation, and interview for all residents receiving medication management, the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on over-the-counter medication packaging. Findings included: - Review of the resident roster revealed the facility provided medication management to the 9 residents. At 2:25 p.m. on 1/5/15, observed certified medication aide (CMA) #C remove a bottle of Biotin (dietary supplement) 5000 micrograms tablets for resident #115. The bottle lacked the first and last name of the resident. CMA #C removed a box of 3 bottles of Minoxidil (hair regrowth treatment). One bottle had the first name of resident #115 and the other 2 bottles contained the resident's initials. CMA #C then removed a bottle of fish oil (dietary supplement) 1000 milligrams capsules, a bottle of calcium (dietary supplement) with D3 600 milligrams tablets, and a bottle of multivitamins (dietary supplement). CMA #C stated these were medications for resident #114. None of the bottles were labeled with the resident's first and	S5313		

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S5313	Continued From page 20 last name. At 2:30 p.m. on 1/5/15, licensed nurse #D stated certified medication aides labeled over-the-counter medications with the resident's name. The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on over-the-counter medication packaging.	S5313		
S5315 SS=D	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as	S5315		

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S5315	Continued From page 21 recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 28-42-205(h)(1) The facility reported a census of 9 residents. The sample included 3 residents and 1 focus review residents. Based on interview and observation for 1 non-sampled resident (#114), the licensed nurse and certified medication aides failed to store a refrigerated controlled medication in a separately locked compartment within the locked medication refrigerator. Findings included: - At 2:35 p.m. on 1/5/15, observed a locked medication refrigerator in the pantry. Certified medication aide #A unlocked the refrigerator and removed a 30 milliliter bottle of Lorazepam Intensol (anti-anxiety medication) 2 milligrams per milliliter. Lorazepam is a controlled medication. Certified medication aide confirmed the Lorazepam was not stored in a separately locked compartment within the refrigerator. The licensed nurse and certified medication aides failed to store a refrigerated controlled medication for resident #114 in a separately locked compartment within the locked medication refrigerator.	S5315		

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