STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	C 10/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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 with investigation of complaint #79656 of the above home plus facility on 9/24/14, 9/25/14, 9/29/14, 9/30/14, 10/1/14, 10/2/14, 10/3/14, and 10/6/14.	S 000		
S 230 SS=F	26-39-102 (b) (c) Admission Advanced Directives Resident Rights b) At the time of admission, adult care home staff shall inform the resident or the resident ' s legal representative, in writing, of the state statutes related to advance medical directives. (1) If a resident has an advance medical directive currently in effect, the facility shall keep a copy on file in the resident ' s clinical record. (2) The administrator or operator, or the designee, shall ensure the development and implementation of policies and procedures related to advance medical directives. (c) The administrator or operator, or the designee, shall provide a copy of resident rights, the adult care home's policies and procedures for advance medical directives, and the adult care home's grievance policy to each resident or the resident's legal representative before the prospective resident signs any admission agreement. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(b)(c) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and interview for 3 (#100, #101, and #102) of 3 residents sampled, the operator failed to at	S 230		

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

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S 230	Continued From page 1 the time of admission, provide each resident or the resident ' s legal representative, in writing, the state statutes related to advanced medical directives and prior to signing an admission agreement the facility's policies and procedures for advanced directives, and the facility's grievance policy. Findings included: - Review of resident records revealed an admission date of 5/15/14 for resident #100, 8/21/14 for resident #101, and 7/31/14 for resident #102. Each resident's record lacked documentation that the resident or the resident's legal representative received at the time of admission, in writing, the state statutes related to advanced medical directives and prior to signing the admission agreement received the facility's policies and procedures for advanced directives, and the facility's grievance policy. Review of the admission agreement for each of the sampled residents revealed the lack of written information related to advanced directives, the facility's policy for advanced directives, and the grievance policy. At 11:45 a.m. on 9/29/14, the operator stated he/she could not locate information provided to residents regarding advanced directives and the grievance policy and procedure. The operator failed to at the time of admission, provide residents #100, #101, and #102 resident or their legal representative, in writing, the state statutes related to advanced medical directives and prior to signing an admission agreement the facility's policies and procedures for advanced directives, and the facility's grievance policy.	S 230		

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S5026 SS=D	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(1)(C) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review, observation and interview for 1 (#102) of 3 residents sampled, the operator failed to ensure the resident was not subjected to exploitation of personal property. Findings included: - Record review for resident #102 revealed an admission date of 7/31/14. The record contained an information sheet from the assisted living facility where resident previously lived that listed diagnoses of chronic pain, hypertension, asthma, allergic rhinitis, and osteoarthritis. The functional capacity screen dated 7/31/14 and completed by licensed nurse #A indicated the resident required supervision with bathing, dressing, toileting, transferring, and walking; was independent with eating; was unable to perform	S5026		

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S5026	Continued From page 3	S5026		

management of medications and treatments; and experienced impaired decision making ability. The cognition section of the functional capacity screen did not indicate an assessment of the resident's cognitive ability. The Operator wrote his/her name on the functional capacity screen as the "Primary person who manages care/financial matters, if other than client."

Review of the progress notes revealed documentation by the Operator at 11:30 a.m. on 9/16/14 of a conversation between the Operator and Resident #102: "[Operator] let resident know (resident's) things will be going to storage in a couple of days and [operator] will be paying for the first month's rent of storage. Resident became upset and threatened [Operator] with calling APS (adult protective services) because of moving (resident ' s) stuff to storage."

During an interview at 11:40 a.m. on 9/29/14, the operator stated he/she moved the resident's property out of the facility garage and to a storage unit on 9/17/14 "because I don't store resident property." Operator stated resident's property was what resident had in an apartment when he/she lived in an assisted living facility. Operator stated the property was moved to the facility garage from the apartment at admission since resident did not have money at time of admission to this facility to pay for a storage unit. Operator provided a contract for the storage unit dated 9/17/14 that listed the operator as the person renting the storage unit and payment of first month rent of $37.00 and subsequent months to be $74.00 plus tax per month. The contract did not contain the resident's name or a signature by the resident. The contract did not indicate that the Operator was acting as the resident ' s

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S5026	Continued From page 4 conservator or attorney-in-fact. During an interview at 2:00 p.m. on 9/29/14, resident #102 stated the operator moved resident's belongings to (facility) garage when he/she moved to the facility because all of the contents of his/her apartment wound not fit in current room. Resident #102 stated "I did not agree to moving things to a storage unit." During an interview at 1:00 p.m. on 9/30/14, Operator stated he/she did not have a written agreement with the resident that the resident's property could not be stored at the facility and that resident would need to rent a storage unit. Operator stated that he/she did not have a written inventory of property placed in the storage unit 9/17/14. Operator stated resident did not go with operator to storage unit when operator rented the unit or when property was moved to the unit. At 3:00 p.m. on 9/30/14, met operator at the storage unit. Operator had key to open the lock. Observed 2 televisions, a couch, king size mattress, dinette table, end table, and numerous boxes, and black plastic bags. Operator confirmed resident did not know where his/her property was stored or have access to the locked storage unit. The operator failed to ensure resident #102 was not subjected to exploitation when the resident #102 ' s personal belonging were moved without permission to a locked unit to which resident #102 had no legal access. The Operator placed the items under the operator ' s name.	S5026		
S5028 SS=E	26-42-101 (f) (3) Staff Treatment of Residents Reporting	S5028		

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S5028	Continued From page 5 (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home 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: KAR 26-42-101(f)(3)(A) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and interview for 2 (#100 and #102) of 3 residents sampled, the operator failed to investigate and report to the department within 24 hours allegations of abuse or neglect.	S5028		

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S5028	Continued From page 6 Findings included: - Record review for resident #100 revealed an admission date of 5/15/14 and diagnoses of cerebral atrophy, Alzheimer's disease, osteoarthritis, and hypertension. The functional capacity screen dated 5/15/14 indicated the resident required supervision with eating; physical assistance with bathing, dressing, toileting, and transferring; was unable to mobilize self; was unable to perform management of medications and medical treatments; was incontinent of urine; and had difficulty communicating and understanding communication. The negotiated service agreement dated 5/15/14 documented the services of physical assistance with bathing, dressing, toileting, incontinence care, mobility per wheelchair, transferring, and administration of medications. The progress notes contained documentation by licensed nurse #A dated 8/10/14 without a specified time that nurse was called due to resident rolling out of bed. The nurse instructed staff to transfer resident to a wheelchair and nurse would come assess resident. The nurse documented an assessment of the resident with no apparent injuries from the fall. Licensed nurse #A documented another resident found resident #100 on the floor and alerted staff. At 4:00 p.m. on 9/25/14, licensed nurse #A stated resident #102 found resident #100 on the floor of resident #100's room. Nurse stated 2 certified employees were in the room of residents #101 and #103 when resident #100 rolled out of bed.	S5028		

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S5028	Continued From page 7	S5028		

Nurse confirmed staff were in the room next to resident 100"s room but did not know if staff heard resident fall. The nurse stated he/she did not investigate the incident to rule out abuse or neglect.

At 12:25 p.m. 9/29/14, operator confirmed he/she did not investigate incident when resident #100 was found on the floor to rule out abuse or neglect of resident.

For resident #100, the operator failed to investigate and report to the department within 24 hours an allegation of abuse or neglect.

- Record review for resident #102 revealed an admission date of 7/31/14. The record contained an information sheet from the assisted living facility where resident previously lived that listed diagnoses of chronic pain, hypertension, asthma, allergic rhinitis, and osteoarthritis.

The functional capacity screen dated 7/31/14 and completed by licensed nurse #A indicated the resident required supervision with bathing, dressing, toileting, transferring, and walking; was independent with eating; was unable to perform management of medications and treatments; and experienced impaired decision making ability. The cognition section of the functional capacity screen did not indicate an assessment of the resident's cognitive ability.

At 3:00 p.m. on 9/25/14, licensed nurse #A stated resident #102 experienced impaired short-term memory, memory recall, and decision making and had no impairment with long-term memory.

The NSA dated 7/29/14 documented supervision with bathing 3 times a week, set-up assistance

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S5028	Continued From page 8 with dressing, and grooming, regular diet with facility meal preparation, housekeeping, laundry, and facility management of medications. During an interview at 2:00 p.m. on 9/29/14, resident #102 stated he/she was taking a bath one evening, approximately 2 weeks after moving to the facility, and bath water was too cold. Resident #102 stated an employee heated 2 pans of water on the stove to add to bath water. Resident stated he/she was in tub and had left hand on side of bathtub trying to get out of tub and hot water from the pan splashed onto the resident ' s left hand. Observed an irregular shaped discolored area on back of left hand between thumb and index finger. Resident stated he/she told operator about the incident and showed area on hand to operator. At 5:00 p.m. on 9/39/14, operator stated he/she was aware of resident's allegation of a burn to hand caused by hot water. Operator stated he/she did not investigate the allegation to rule out abuse or neglect. For resident #102, the operator failed to investigate and report to the department within 24 hours an allegation of abuse or neglect.	S5028		
S5029 SS=F	26-42-101 (g) Availability of policies and procedures (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during normal business hours. A notice of availability	S5029		

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S5029	Continued From page 9 shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(g) The facility reported a census of 5 residents. The sample included 3 residents. Based on observation and interview for all residents, legal representatives of residents, case managers, and families of residents, the operator failed to post a notice of the availability of the facility policies and procedures related to resident services. Findings included: - During tour of the facility at 3:45 a.m. on 9/24/14, noted the absence of a notice regarding the location of the facility policies and procedures for persons wishing to review the policies and procedures. At 4:55 p.m. on 9/24/14, the operator stated he/she kept the facility policy and procedure manual in the basement. Operator confirmed he/she did not post a notice to inform residents, case managers, and families of residents regarding the availability of the facility policies and procedures. For all residents, legal representatives of residents, case managers, and families of residents, the operator failed to post a notice of the availability of the facility policies and procedures related to resident services.	S5029		
S5030 SS=D	26-42-101 (h) Power of Attorney, Guardianship, Conservator	S5030		

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S5030	Continued From page 10 (h) Power of attorney, guardianship, and conservatorship. Authority as a power of attorney, durable power of attorney for health care decisions, guardian, or conservator shall not be exercised by anyone employed by or having a financial interest in the home, unless the person is related to the resident within the second degree. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(h) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and interview for 1 (#102) of 3 residents sampled, the owner/operator of the facility failed to ensure authority as a durable power of attorney for health care decisions was not exercised by anyone employed by or having a financial interest in the home, unless the person was related to the resident within the second degree. Findings included: - Record review for resident #102 revealed an admission date of 7/31/14. The record contained an information sheet from the assisted living facility where resident previously lived that listed diagnoses of chronic pain, hypertension, asthma, allergic rhinitis, and osteoarthritis. The functional capacity screen dated 7/31/14 and completed by licensed nurse #A indicated the resident required supervision with bathing, dressing, toileting, transferring, and walking; was independent with eating; was unable to perform management of medications and treatments; and	S5030		

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S5030	Continued From page 11	S5030		

experienced impaired decision making ability. The cognition section of the functional capacity screen did not indicate an assessment of the resident's cognitive ability. The operator wrote his/her name on the functional capacity screen as the "Primary person who manages care/financial matters, if other than client."

The record contained documentation by a licensed clinical social worker dated 7/28/14 that resident needed a durable power of attorney to help direct and guide resident's life. The social worker documented "Have concluded that (resident) is unable to make realistic and responsible decisions for (resident's) health and wellbeing. (Resident's) ability to reason is poor."

At 3:05 p.m. on 9/25/14, licensed nurse #A stated resident experienced impaired short-term memory, decision making, and memory recall.

The record contained a notarized "Durable Power of Attorney for Healthcare Decisions" dated and signed by resident #102 on 7/31/14 that listed the operator as the person to make healthcare decisions for the resident if resident was unable to make or communicate own wishes.

At 11:50 a.m. on 9/29/14, operator confirmed he/she was listed as the durable power of attorney for healthcare decisions for resident #102. Operator stated he/she was not related to resident #102.

For resident #102, the owner/operator of the facility failed to ensure authority as a durable power of attorney for health care decisions was not exercised by anyone employed by or having a financial interest in the home, unless the person was related to the resident within the second

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S5030	Continued From page 12 degree.	S5030		
S5040 SS=F	26-42-101 (j) Emergency Telephone (j) Emergency telephone. Each administrator or operator shall ensure that the residents and employees have access to a telephone for emergency use at no cost. Each administrator or operator shall ensure that the names and telephone numbers of persons or places commonly required in emergencies are posted adjacent to this telephone. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(j) The facility reported a census of 5 residents. The sample included 3 residents. Based on observation and interview for all residents, the operator failed to ensure the names and telephone numbers of persons or places commonly required in emergencies were posted adjacent to facility telephone used by residents. Findings included: - During tour of the facility observed emergency telephone numbers posted on a paper attached to the inside of the entryway closet door. During an interview at 4:55 p.m. on 9/24/15, the operator confirmed residents did not have access to emergency telephone numbers with the numbers posted by the telephone in the kitchen for resident use. For all residents, the operator failed to ensure the	S5040		

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S5040	Continued From page 13 names and telephone numbers of persons or places commonly required in emergencies were posted adjacent to facility telephone used by residents.	S5040		
S5065 SS=D	26-42-200 (a) Resident Criteria (a) The administrator or operator of each home plus shall ensure the development and implementation of written admission, transfer, and discharge policies that protect the rights of each resident, pursuant to K.A.R. 26-39-102. In addition, the administrator or operator shall ensure that any resident who has one or more of the following conditions is not admitted or retained unless the negotiated service agreement includes services sufficient to meet the needs of the resident: (1) Incontinence, if the resident cannot or will not participate in management of the problem; (2) immobility, if the resident is totally dependent on another person ' s assistance to exit the building; (3) any ongoing condition requiring two or more persons to physically assist the resident; (4) any ongoing, skilled nursing intervention needed 24 hours a day; or (5) any behavioral symptom that exceeds manageability. This REQUIREMENT is not met as evidenced by: KAR 26-42-200(a)(2) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review, observation, and interview for 1 (#100) of 3 residents sampled, the operator retained, in the	S5065		

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(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
S5065	Continued From page 14	S5065		

facility, resident #100 who was totally dependent on another person's assistance to exit the building. The operator failed to ensure the negotiated service agreement included services sufficient to meet the needs of the resident.

Findings included:

- Record review for resident #100 revealed an admission date of 5/15/14 and diagnoses of cerebral atrophy, Alzheimer's disease, osteoarthritis, and hypertension.

The functional capacity screen dated 5/15/14 indicated the resident required supervision with eating; physical assistance with bathing, dressing, toileting, and transferring; was unable to mobilize self; was unable to perform management of medications and medical treatments; was incontinent of urine; and had difficulty communicating and understanding communication.

The negotiated service agreement dated 5/15/14 documented the services of physical assistance with bathing, dressing, toileting, incontinence care, mobility per wheelchair, transferring, and administration of medications.

At 11:07 a.m. on 9/29/14, observed resident #100 sitting in a chair in the living room. Resident attempted to scoot to edge of chair and certified medication aide (CMA) # E asked resident if he/she wanted to go to bed. Observed CMA #E transfer resident from living room chair to wheelchair and wheel resident to the resident's room. Observed CMA #E then transfer resident from wheelchair to bed. Observed that resident required total assistance with both transfers.

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S5065	Continued From page 15 During an interview at 12:25 p.m. on 9/29/14, the operator stated resident would require total assistance to exit the building. The negotiated service agreement dated 5/15/14 lacked services related to the resident's need for total assistance to exit the building. The operator retained, in the facility, resident #100 who was totally dependent on another person's assistance to exit the building. The operator failed to ensure the negotiated service agreement included services sufficient to meet the needs of the resident.	S5065		
S5066 SS=D	26-42-200 (b) Resident Criteria Restraints (b) Each administrator or operator shall ensure that any resident whose clinical condition requires the use of physical restraints is not admitted or retained. This REQUIREMENT is not met as evidenced by: KAR 26-42-200(b) The facility reported a census of 5 residents. The sample included 3 residents. Based on observation, record review, and interview for 1 (#100) of 3 residents sampled, staff members utilized a mattress as a restraint to keep resident from falling out of bed. The operator failed to ensure that a resident whose clinical condition required the use of a physical restraint was not admitted or retained. Findings included:	S5066		

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S5066	Continued From page 16 - During tour of the facility at 3:45 p.m. on 9/24/14, observed a room that certified nursing assistant (CNA) #C stated was the room for 2 residents (#101 and #104). Observed a twin size mattress turned on its side leaning against something with a wheelchair pushed up against the mattress. CNA #C walked over to the mattress and began talking to a resident. Observed resident #100 in a twin size bed with one side of bed against wall and the mattress and wheelchair on the other side of the bed. CNA #C stated resident required the mattress up against the side of the bed because resident would roll out of bed. Record review for resident #100 revealed an admission date of 5/15/14 and diagnoses of cerebral atrophy, Alzheimer's disease, osteoarthritis, and hypertension. The functional capacity screen dated 5/15/14 indicated the resident required supervision with eating; physical assistance with bathing, dressing, toileting, and transferring; was unable to mobilize self; was unable to perform management of medications and medical treatments; was incontinent of urine; and had difficulty communicating and understanding communication. The functional capacity screen did not indicate the resident was at risk for falls. The negotiated service agreement dated 5/15/14 documented the services of physical assistance with bathing, dressing, toileting, incontinence care, mobility per wheelchair, transferring, and administration of medications. The negotiated service agreement lacked a description of services for the resident's risk of rolling out of bed.	S5066		

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S5066	Continued From page 17 The progress notes contained an entry by licensed nurse #A that resident rolled out of bed on 8/10/14. At 1:30 p.m. on 9/25/14, observed resident #100 in bed with a mesh and metal side rail on bed. Operator stated used mattress propped up against side bed when resident was in bed for longer periods. Operator stated mattress and rail were required to keep resident from sitting on edge of bed because resident would forget that he/she could not get up on own. At 4:00 p.m. on 9/25/14, licensed nurse #A stated the resident's family member requested the mattress be placed up on side to keep resident from rolling out of bed. Licensed nurse confirmed resident could not get out of bed with mattress propped up beside bed. The admission agreement for resident #100 signed by resident's family member and dated 5/14/14 documented the facility was a restraint free home. At 5:00 p.m. on 9/25/14, the operator stated that staff would be instructed to place mattress flat on floor next to bed instead of propped up on side against bed. Staff members utilized a mattress as a restraint to keep resident #100 from falling out of bed. The operator failed to ensure that a resident whose clinical condition required the use of a physical restraint was not admitted or retained.	S5066		
S5080 SS=E	26-42-201 (a) (b) Functional Capacity Screen on Admission	S5080		

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S5080	Continued From page 18 (a) On or before each individual ' s admission to a home plus, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the home, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(a) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and observation for 2 (#100 and #102) of 3 residents sampled, the licensed nurse failed to complete the functional capacity screen following each element and definition as specified by the department. Findings included: - Record review for resident #100 revealed an admission date of 5/15/14 and diagnoses of cerebral atrophy, Alzheimer's disease, osteoarthritis, and hypertension.	S5080		

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S5080	Continued From page 19 The functional capacity screen dated 5/15/14 indicated the resident experienced impaired long-term memory with intact short-term memory, decision making, and memory recall. The functional capacity screen lacked the signature of the person conducting the screening. At 12:25 p.m. on 9/29/14, the operator stated the licensed nurse who conducted the functional capacity screen apparently used a score of '1' to indicate no problem with long-term memory and '0' to indicate a problem with short-term memory, decision making, and memory recall. The department's functional capacity screen manual defines the cognition section of the screen to be scored a '0' if no impairment and a score of '1' if there is impairment in the areas of short-term memory, long-term memory, memory recall, and decision making. Person conducting the screening is instructed to sign and date the functional capacity screen. The licensed nurse failed to complete the functional capacity screen for resident #100 following each element and definition as specified by the department. - Record review for resident #102 revealed an admission date of 7/31/14. The record contained an information sheet from the assisted living facility where resident previously lived that listed diagnoses of chronic pain, hypertension, asthma, allergic rhinitis, and osteoarthritis. The functional capacity screen dated 7/31/14 and completed by licensed nurse #A documented a score of '3' for short-term memory, '1' for long-term memory, '3' for memory recall, and '3' for decision making.	S5080		

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S5080	Continued From page 20 The department's functional capacity screen manual defines the cognition section of the screen to be scored a '0' if no impairment and a score of '1' if there is impairment in the areas of short-term memory, long-term memory, memory recall, and decision making. At 3:00 p.m. on 9/25/14, licensed nurse #A stated resident #102 experienced impaired short-term memory, memory recall, and decision making and no impairment with long-term memory. Licensed nurse #A stated he/she did not have a functional capacity screen manual to follow when completing the screening. The licensed nurse failed to complete the functional capacity screen for resident #102 following each element and definition as specified by the department.	S5080		
S5105 SS=F	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	S5105		

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S5105	Continued From page 21 payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)(2)(3) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and interview for 3 (#101, #102, and #100) of 3 residents sampled, the operator failed to ensure the development of a written negotiated service agreement (NSA) 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 a description of services to be provided, the provider of the service and the party responsible for payment when services were provided by an outside resource. Findings included: - Record review for resident #101 revealed an admission date of 8/21/14 and diagnoses of skull fracture with subarachnoid hemorrhage, hypertension, and dysphagia. The functional capacity screen dated 8/21/14 indicated the resident was independent with eating and mobility in wheelchair; required physical assistance with bathing, dressing, toileting, and transferring; unable to perform management of medications and treatments; was occasionally incontinent of urine; and experienced impaired long-term memory, memory recall, and decision making.	S5105		

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S5105	Continued From page 22 The NSA dated 8/21/14 documented services provided by facility staff of physical assistance with bathing, dressing, toileting, transferring, grooming, meal preparation, nectar thick liquids, housekeeping, laundry, management of medications and medical treatments, and "speech for dysphagia." The NSA lacked the name of the provider of speech therapy and the payment source. The NSA contained the signature of the operator and licensed nurse #A. The NSA lacked the signature of the resident, the resident's legal representative, or case manager. The resident's record contained a medical care provider's written order dated 8/19/14 for home health to assess for nursing, aide, therapy, and licensed social worker. The record contained a medical care provider's written order dated 8/19/14 to continue same orders from the facility resident was transferring from to be admitted to this facility. The physician order sheet documented resident to receive a low concentrated sweets diet with nectar thick liquids. The record contained an order dated 8/26/14 for blood sugar monitoring with a glucometer every Monday before breakfast and 2 hours after one meal. At 4:35 p.m. on 9/24/14, certified medication aide #E stated certified medication aides tested the resident blood sugar with a glucometer. At 12:55 p.m. on 9/25/14, resident stated he/she received physical therapy, occupational therapy, and speech therapy visits at the facility. The negotiated service agreement lacked a description of the services of a low concentrated sweets diet; blood glucose testing by certified	S5105		

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S5105	Continued From page 23	S5105		

medication aides; physical and occupational therapy; and social work.

At 3:55 p.m. on 9/25/14, licensed nurse #A stated resident received physical, occupational, and speech therapy visits and also visits from a social worker. Licensed nurse #A confirmed the NSA lacked a description of services, the name of the provider, and the payment source for services by the outside provider. Licensed nurse #A stated he/she completed the NSA without resident's collaboration.

The operator failed to ensure the development of a written NSA for resident #101 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 a description of services to be provided, the provider of the service and the party responsible for payment when services were provided by an outside resource.

- Record review for resident #102 revealed an admission date of 7/31/14. The record contained an information sheet from the assisted living facility where resident previously lived that listed diagnoses of chronic pain, hypertension, asthma, allergic rhinitis, and osteoarthritis.

The functional capacity screen dated 7/31/14 and completed by licensed nurse #A indicated the resident required supervision with bathing, dressing, toileting, transferring, and walking; was independent with eating; was unable to perform management of medications and treatments; and

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S5105	Continued From page 24 experienced impaired decision making ability. The NSA dated 7/29/14 documented supervision with bathing 3 times a week, set-up assistance with dressing, and grooming, regular diet with facility meal preparation, housekeeping, laundry, and facility management of medications. The NSA contained the signature of licensed nurse #A. The record contained documentation by a licensed clinical social worker of visits made to the resident in the facility. The NSA lacked a description of this service, the person or agency providing the service, and the party responsible for payment of the service. During an interview at 12:00 p.m. on 9/29/14, operator confirmed the NSA lacked a description of service of the social worker and payment source. Operator stated resident was not involved in the development of the NSA. The operator failed to ensure the development of a written NSA 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 a description of services to be provided, the provider of the service and the party responsible for payment when services were provided by an outside resource. - Record review for resident #100 revealed an admission date of 5/15/14 and diagnoses of cerebral atrophy, Alzheimer's disease, osteoarthritis, and hypertension.	S5105		

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S5105	Continued From page 25 The functional capacity screen dated 5/15/14 indicated the resident required supervision with eating; physical assistance with bathing, dressing, toileting, and transferring; was unable to mobilize self; was unable to perform management of medications and medical treatments; was incontinent of urine; and had difficulty communicating and understanding communication. The NSA dated 5/15/14 documented it was an agreement between the resident's family member and the facility for the care and services for resident #100. The NSA documented services of physical assistance with bathing, dressing, incontinence care, toileting, mobility per wheelchair, 2-person transfer, grooming, eating, and medication management. The NSA contained the signatures of a registered nurse, the operator, and the resident. The NSA lacked the signature of the resident's family member. The resident's record contained a medical care provider's written order dated 8/26/14 for a mechanical soft diet with ground meat with gravy. The progress notes contained an entry by a certified employee 8/2/14 that the resident had an open area on bottom. On 8/10/14, licensed nurse #A documented resident rolled out of bed. At 4:55 p.m. on 9/29/14, certified medication aide (CMA) stated resident had rolled out of bed before and he/she tried to monitor resident frequently. CMA stated he/she checks resident every 2 hours to see if resident needs incontinence care in order to prevent skin breakdown,	S5105		

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S5105	Continued From page 26 The resident's NSA lacked a description of services for a mechanical soft diet with ground meat and gravy; measures to reduce the resident's risk of rolling out of bed; and measures to reduce resident's risk for skin breakdown. During an interview at 12:25 p.m. on 9/29/14, the NSA for resident #100 was not completed in collaboration with the resident's family member. The operator failed to ensure the development of a written NSA for resident #100 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.	S5105		
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 5 residents. The sample included 3 residents. Based on interview and record review for 1 (#101) of 3 residents sampled and 1 non-sampled resident (#103) , the licensed nurse failed to delegate blood sugar testing of these residents with a glucometer to	S5165		

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S5165	Continued From page 27	S5165		

certified medication aides respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.

Findings included:

- At 4:35 p.m. on 9/24/14, certified medication aide (CMA) #E stated CMAs performed glucometer tests on 2 residents (#101 and #103).

During an interview at 3:00 p.m. on 9/25/14, licensed nurse #A stated he/she did not instruct CMAs on the use of glucometer and did not observe each CMA perform the procedure.

Record review for resident #101 revealed an admission date of 8/21/14 and diagnoses of skull fracture with subarachnoid hemorrhage, hypertension, and dysphagia. The functional capacity screen dated 8/21/14 indicated the resident was unable to perform management of medications and medical treatments. The negotiated service agreement dated 8/21/14 documented the service of facility management of medications and medical treatments. The record contained a medical care provider's order dated 8/26/14 for blood sugar testing with glucometer every Monday fasting and 2 hours after noon meal.

Review of the files of CMA #D, CMA #E, and CMA #F on 9/29/14 revealed the lack of documentation of licensed nurse delegation for each CMA to perform glucometer testing of residents.

At 3:25 p.m. on 9/29/14, the operator stated that the licensed nurse did not delegate glucometer testing of blood sugar to CMAs.

The licensed nurse failed to delegate blood sugar

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S5165	Continued From page 28 testing of residents #101 and #103 with a glucometer to certified medication aides respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S5165		
S5166 SS=F	26-42-204 (f) Delegation of Duties (f) Each administrator or operator shall ensure that a licensed nurse is available to provide immediate direction to medication aides and nurse aides for residents who have unscheduled needs. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(f) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and interview for all residents, the operator failed to ensure that a licensed nurse was available to provide immediate direction to medication aides and nurse aides for residents who had unscheduled needs. Finding included: - During an interview at 4:30 p.m. on 9/24/14, operator stated licensed nurse #A was a licensed practical nurse and came to the facility 3 times a week and was on call for residents' unscheduled needs. At 3:00 p.m. on 9/25/14, licensed nurse #A stated he/she came to facility one time a week to check on residents. Nurse stated he/she worked 12 hour shifts at a sub-acute care facility 3 days a	S5166		

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S5166	Continued From page 29	S5166		

week. Nurse confirmed he/she was on-call 24 hours a day, 7 days a week for the home plus facility.

At 3:50 p.m. on 9/25/14, certified medication aide #E stated that if a resident required an anti-anxiety medication on an as needed basis that he/she would not call the licensed nurse for an assessment and instruction to administer the medication but would call the operator instead. Licensed nurse #A confirmed that he/she was not called for an assessment of a resident prior to administration of an anti-anxiety medication.

Review of the record for resident #102 revealed documentation in the progress notes by licensed nurse #A on 9/18/14 that resident was verbally aggressive and physically intimidating to staff. Nurse received order from medical care provider to send resident to hospital for mental evaluation. The entry lacked a time.

During an interview at 1:00 p.m. on 9/30/14 with licensed nurse #A and the operator, licensed nurse #A stated the entry had to have been 7:30 p.m. or 8:00 p.m. because he/she had worked a 12 hour shift at another job that day. Operator could not recall if he/she had called licensed nurse #A during the day regarding resident's behaviors. Licensed nurse #A stated he/she could not have a personal cell phone with him/her while at the other job and he/she did not know if he/she could receive phone calls from the home plus facility while working at other job.

For all residents, the operator failed to ensure that a licensed nurse was available to provide immediate direction to medication aides and nurse aides for residents who had unscheduled needs.

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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 5 residents. The sample included 3 residents. Based on record review and interview for 3 (#102, #101, and #100), the operator failed to ensure all health care services were provided to residents by qualified staff in accordance with acceptable standards of practice. Findings included: - Record review for resident #102 revealed an admission date of 7/31/14. The record contained an information sheet from the assisted living facility where resident previously lived that listed diagnoses of chronic pain, hypertension, asthma, allergic rhinitis, and osteoarthritis. The functional capacity screen dated 7/31/14 and completed by licensed nurse #A indicated the resident required supervision with bathing, dressing, toileting, transferring, and walking; was independent with eating; was unable to perform management of medications and treatments; and experienced impaired decision making ability. The negotiated service agreement dated 7/29/14 documented supervision with bathing 3 times a week, set-up assistance with dressing, and grooming, regular diet with facility meal	S5171		

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preparation, and facility management of medications. The negotiated service agreement contained the name of licensed nurse #A as the licensed nurse responsible for the health care service plan.

The resident's record lacked written and signed medical care provider's orders for the medications the resident received.

At 3:05 p.m. on 9/25/14, licensed nurse #A confirmed the resident's record lacked written and signed medical care provider's orders for the medications the resident received. Licensed nurse #A stated to ask operator for the signed medical care provider orders.

At 12:00 p.m. on 9/29/14, operator stated he/she did not know anything about signed medical care provider's orders for resident #102.

The progress notes contained documentation by certified medication side #F dated 7:00 p.m. 9/16/14 to 7:00 a.m. 9/17/14 shift, that at 3:45 a.m. resident came into the living room wanting phone number to call an ambulance and the employee told resident he/she did not know the number. The entry lacked evidence that certified staff questioned resident regarding health concerns and did not notify licensed nurse for direction. Resident did notify emergency medical services on own and was taken to hospital emergency department. The record contained emergency department documentation that resident was treated for arthralgia.

During an interview at 1:00 p.m. on 9/30/14, licensed nurse #A stated certified staff contacted him/her on 9/17/4 but he/she could not come to facility to assess the resident because he/she had

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S5171	Continued From page 32 to go to another job. The progress notes contained documentation by the operator at 12:12 p.m. on 9/18/14 that resident complained of being dizzy and hearing voices. The entry lacked documentation of licensed nurse notification of the resident's symptoms. During an interview at 1:00 p.m. on 9/30/14, the operator and licensed nurse #A could not recall if operator called licensed nurse #A regarding the resident's symptoms of dizziness and hearing voices on 9/18/14. Licensed nurse #A stated he/she was at another job and was unable to have personal cell phone while working and that facility does not always give outside calls to him/her. During an interview at 2:00 p.m. on 9/29/14, resident #102 stated that approximately 2 weeks after admission to the facility he/she received a burn to the back of left hand caused by hot water. Resident #102 stated he/she showed the burn to the operator. At 5:00 p.m. on 9/29/14, operator stated he/she was aware of the resident's report of a burn to hand. Operator stated he/she did not do anything since he/she did not see a break in skin or redness. The operator failed to ensure all health care services were provided to resident #102 by qualified staff in accordance with acceptable standards of practice. - Record review for resident #101 revealed an admission date of 8/21/14 and diagnoses of skull fracture with subarachnoid hemorrhage,	S5171		

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hypertension, and dysphagia.

The functional capacity screen dated 8/21/14 indicated the resident was independent with eating and mobility in wheelchair; required physical assistance with bathing, dressing, toileting, and transferring; unable to perform management of medications and treatments; was occasionally incontinent of urine; and experienced impaired long-term memory, memory recall, and decision making.

The negotiated service agreement dated 8/21/14 documented services provided by facility staff of physical assistance with bathing, dressing, toileting, transferring, grooming, meal preparation, nectar thick liquids, and management of medications and medical treatments. The negotiated service agreement contained the name of licensed nurse #A as the licensed nurse responsible for the health care service plan.

Comparison of the written and signed medical care provider's orders and the 9/1/14 through 9/30/14 medication administration record revealed the resident did not receive Duoneb (to treat symptoms of chronic obstructive pulmonary disease) 0.5/3.0 solution, 1 vial, per nebulizer at 8:00 a.m. and 6:00 p.m.; Glucerna dietary supplement drink 1 can between meals and at bedtime; skin prep to bilateral great toes and cover with Band-Aid strip 2 times a week; and skin prep to left heel daily.

At 4:35 p.m. on 9/29/14, certified medication aides #E stated resident did not have the nebulizer to receive the Duoneb breathing treatment; resident refused Glucerna shakes; and no longer required the skin treatment to toes and

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S5171	Continued From page 34 heel. The record contained a verbal orders from a medical care provider dated 8/26/14 to re-start Tramadol 50 milligrams by mouth every 6 hours as needed. The order lacked a medical care provider's signature within 7 days. During an interview at 3:55 p.m. on 9/25/14, licensed nurse #A stated the operator faxed verbal orders to the medical care provider for signature and could not explain why verbal order not signed within 7 days. Licensed nurse #A confirmed he/she did not obtain the medical care provider's signature. The operator failed to ensure all health care services were provided to resident #101 by qualified staff in accordance with acceptable standards of practice. - Record review for resident #100 revealed an admission date of 5/15/14 and diagnoses of cerebral atrophy, Alzheimer's disease, osteoarthritis, and hypertension. The functional capacity screen dated 5/15/14 indicated the resident required supervision with eating; physical assistance with bathing, dressing, toileting, and transferring; was unable to mobilize self; was unable to perform management of medications and medical treatments; was incontinent of urine; and had difficulty communicating and understanding communication. The negotiated service agreement dated 5/15/14 documented the services of physical assistance with bathing, dressing, incontinence care, toileting, mobility per wheelchair, 2-person	S5171		

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transfer, grooming, eating, and medication management. The negotiated service agreement contained the name of a licensed nurse no longer employed by the facility.

At 3:45 p.m. on 9/24/14, entered the room of resident #100 with certified nursing assistant (CNA) #C and observed a twin size mattress turned on its side leaning against something with a wheelchair pushed up against the mattress. CNA #C walked over to the mattress and began talking to a resident. Observed resident #100 in a twin size bed with one side of bed against wall and the mattress and wheelchair on the other side of the bed. CNA #C stated resident required the mattress up against the side of the bed because resident would roll out of bed.

At 2:45 a.m. on 9/29/14, CNA #C stated he/she turned and positioned the mattress up against the bed to keep resident from rolling out of bed because this was how it was when he/she started to work at the facility. CNA #C started at the facility on 8/8/14.

During an interview at 1:45 p.m. on 9/30/14, operator stated initially staff was instructed to place the twin size mattress on the floor as a fall mat. Operator stated staff then began turning mattress up on side against the bed.

The progress notes contained an entry dated 8/2/14 at 4:00 p.m. by a certified medication aide that resident had a small sore on bottom and nurse came today and got an order for Duoderm to heal resident's bottom. The 9/1/14 through 9/30/14 medication administration record contained an entry for Duoderm dressing to open area on coccyx and change every 2 days and as needed. The resident's record lacked a written

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S5171	Continued From page 36 medical care provider ' s order for Duoderm as entered on the medication administration record. At 11:07 a.m. on 9/29/14, observed certified medication aide (CMA) #E transfer resident #100 from wheelchair to bed and provide incontinence care. CMA #E pointed out the small area to right of resident's coccyx and applied Calmoseptine ointment. CMA #E stated resident did not require a Duoderm dressing. The operator failed to ensure all health care services were provided to resident #100 by qualified staff in accordance with acceptable standards of practice.	S5171		
S5185 SS=F	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)	S5185		

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S5185	Continued From page 37 The facility reported a census of 5 residents. The sample included 3 residents. Based on interview and record review for 2 (#101 and #100) of 2 residents requiring a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, the operator failed to ensure meals were prepared according to instructions from a medical care provider or licensed dietitian. Findings included: - Record review for resident #101 revealed an admission date of 8/21/14 and diagnoses of skull fracture with subarachnoid hemorrhage, hypertension, and dysphagia. The functional capacity screen dated 8/21/14 indicated the resident was independent with eating and experienced impaired long-term memory, memory recall, and decision making. The NSA dated 8/21/14 documented facility meal preparation and resident required nectar thick liquids. The physician order sheet contained documentation of a low concentrated sweets diet with nectar thick liquids. During an interview at 11:45 a.m. on 9/29/14, operator stated "Just going by what we think" to follow a low concentrated sweets diet and nectar thick liquids. Certified medication aide #E stated the speech therapist instructed him/her to add 1 scoop of Thick-it to 8 ounces of liquid for a nectar consistency. Operator confirmed the lack of instructions from a medical care provider or licensed dietitian on how to prepare the	S5185		

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therapeutic diet and thickened liquids.

The operator failed to ensure a therapeutic diet and nectar thick liquids ordered for resident #101 were prepared according to instructions from a medical care provider or licensed dietitian.

- Record review for resident #100 revealed an admission date of 5/15/14 and diagnoses of cerebral atrophy, Alzheimer's disease, osteoarthritis, and hypertension.

The functional capacity screen dated 5/15/14 indicated the resident required supervision with eating.

The NSA dated 5/15/14 documented facility preparation of meals and did not document a special diet order for the resident.

The physician order sheet contained documentation of a mechanical soft diet with ground meat and gravy.

At 5:45 p.m. on 9/24/14, observed resident feeding self the evening meal of chili burrito, rice, greens beans, and fruit cocktail. Observed that burrito had been cut into small pieces.

At 1:00 p.m. on 9/30/14, observed resident at table eating a meal of chicken and baked beans. Observed chicken had been shredded but not ground and no gravy over chicken.

During an interview at 1:00 p.m. on 9/30/14, operator confirmed staff did not have instructions from a medical care provider or licensed dietitian to follow in preparing diet for resident.

The operator failed to ensure the therapeutic diet

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S5185	Continued From page 39 ordered for resident #100 was prepared according to instructions from a medical care provider or licensed dietitian.	S5185		
S5186 SS=F	26-42-206 (d) Dietary Services Menus (d) The menus shall be planned in advance and in accordance with the dietary guidelines adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(d) The facility reported a census of 5 residents. The sample included 3 residents. Based on observation and interview for all residents, the operator failed to ensure menus were planned in advance and in accordance with the dietary guidelines adopted by reference in K.A.R. 26-39-105. Findings included: - During tour of the facility at 3:45 p.m. on 9/24/14, noted the lack of a menu plan posted. At 4:55 p.m. on 9/24/14, operator stated menus were not planned in advance. Observed evening meal on 9/24/14 of chili burrito, rice, green beans, and fruit cocktail. At 12:20 p.m. on 9/25/14, certified employee #C stated lunch food items today of chicken pot pie, grapes and cranberries. Certified employee #C stated he/she did not have a weekly menu to follow and he/she used whatever food items were	S5186		

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S5186	Continued From page 40 on hand to put a meal together. For all residents, the operator failed to ensure menus were planned in advance and in accordance with the dietary guidelines adopted by reference in K.A.R. 26-39-105.	S5186		
S5190 SS=F	26-42-206 (d) Dietary Services (d)(1) Menu plans shall be available to each resident on at least a weekly basis. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(d)(1) The facility reported a census of 5 residents. The sample included 3 residents. Based on observation and interview for all residents, the operator failed to ensure menu plans were available to each resident on at least a weekly basis. Findings included: - During tour of the facility at 3:45 p.m. on 9/24/14, noted the lack of a menu plan posted. At 4:55 p.m. on 9/24/14, operator stated menus were not planned in advance so menus were not available to residents on a weekly basis. The operator failed to ensure menu plans were available to each resident on at least a weekly basis.	S5190		

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S5191 SS=F	26-42-206 (d) (2) Dietary Services Resident Input in Menu (d) (2) A method shall be established to incorporate input by residents in the selection of food to be served and scheduling of meal service. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(d)(2) The facility reported a census of 5 residents. The sample included 3 residents. Based on interview for all residents, the operator failed to establish a method to incorporate input by residents in the selection of food to be served and scheduling of meal service. Findings included: - During tour of the facility kitchen at 4:55 p.m. on 9/24/14, the operator stated residents did not have input into selection of food to be served. Operator stated that staff followed each resident's diet order for food items served. At 12:20 p.m. on 9/25/14, certified employee #C stated he/she used whatever food items were on hand to put a meal together. At 10:50 a.m. on 9/29/14, resident #101 stated he/she probably could request certain food items but was taught by his/her parent to eat what was served. The operator failed to establish a method to incorporate input by residents in the selection of food to be served and scheduling of meal service.	S5191		

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S5195	Continued From page 42	S5195		
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 5 residents. The sample included 3 residents. Based on observation and interview for all residents, the operator failed to ensure staff stored all food under safe and sanitary conditions. Findings included: - During tour of the facility kitchen at 3:50 p.m. on 9/24/14 observed the following food items not labeled with the date package was opened in the upper cabinet to left of sink: Chicken fry seasoning mix Bread sack with best if purchased by 9/22/14, 2 slices of bread remaining Medium egg noodles, partial one pound bag Cheese puffs Corn meal partial 5 pound bag	S5195		

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S5195	Continued From page 43 Spaghetti partial 32 ounce box All of the above were open without a secure closure of the package. Package of hot dog buns closed with a twist tie. Three hot dog buns remained in the package with a manufacturer's best by date of 9/14/14. Lower cabinet to left of cooktop, observed a glass jar loosely filled with a cloudy substance with floating sediment. The jar was loosely covered with crumpled aluminum foil. Observed an old Crisco shortening can. Removed plastic lid and observed what appeared to be solidified fat. These containers lacked a label in order to identify the contents. Operator stated it was fat from meat drippings used to season vegetables. In side-by-side refrigerator freezer observed the following stored in the freezer section: 3 bean and cheese burritos in the original package, opened and not securely sealed, without a date package was opened. Operator stated the burritos were to be for evening meal today. Plastic zip-lock bag with frozen contents unlabeled to identify the food and lacked date item was placed in freezer. Operator stated this was hamburger meat. Pizza roll box, opened at one end with 7-8 rolls remaining and no open date on package. Catfish nuggets, partial bag, in original plastic bag with opened end rolled around the package. Plastic zip-lock bag with 2 pieces of frozen food	S5195		

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S5195	Continued From page 44 without a label to identify contents. Operator stated this was fish. Black Angus patties box, opened with several patties wrapped in aluminum foil. Fish fillet box open with 4 unwrapped fillets. Pork sausage bag. End of bag open with 8 patties in the bag. Open plastic bag of unidentifiable frozen food loosely covered in torn, crumpled aluminum foil. Operator stated this was ham pieces. At 5:45 p.m. on 9/24/14, observed 3 residents eating evening meal of chili burrito, rice, green beans, and fruit cocktail. Two residents were out of the facility at this time. For all residents, the operator failed to ensure staff stored all food under safe and sanitary conditions.	S5195		
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; and	S5215		

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S5215	Continued From page 45 (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)(1)(2)(3) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and interview for all residents and employees, the operator failed to ensure disaster and emergency preparedness by ensuring the performance of orientation of new employees at the time of employment to the facility ' s emergency management plan; education of each resident upon admission to the facility regarding emergency procedures; and quarterly review of the facility's emergency management plan with employees and residents. Findings included: - Record review for the 3 sampled residents revealed admission dates of resident #100 on 5/15/14, resident #101 on 8/21/14, and resident #102 on 7/31/14. At 10:30 a.m. on 9/25/14, the operator stated he/she did not educate residents at the time of admission to the facility regarding the emergency management plan procedures. Operator stated new employees reviewed the plan for tornado and fire but not the entire plan. Operator stated he/she did not have a process in place to ensure a quarterly review of the emergency management plan with residents and employees.	S5215		

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S5215	Continued From page 46 For all residents and employees, the operator failed to ensure disaster and emergency preparedness by ensuring the performance of orientation of new employees at the time of employment to the facility ' s emergency management plan; education of each resident upon admission to the facility regarding emergency procedures; and quarterly review of the facility's emergency management plan with employees and residents.	S5215		
S5220 SS=F	26-42-104 (e) Emergency Plan Available (e) Each administrator or operator shall make the emergency management plan available to the staff, residents, and visitors. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(e) The facility reported a census of 5 residents. The sample included 3 residents. Based on observation and interview for all residents and visitors, the operator failed to make the emergency management plan available to residents and visitors. Findings included: - At 4:55 p.m. on 9/24/14, the operator stated he/she kept the emergency management plan in the basement of the facility. Operator confirmed the emergency management plan was not available to residents and visitors. For all residents and visitors, the operator failed to make the emergency management plan available to residents and visitors.	S5220		

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S5230 SS=F	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 5 residents. The sample included 3 residents. Based on record review and interview for 3 (#100, #101, and #102) of 3 residents sampled and 6 employee files reviewed, the operator 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. 26-39-105. Findings included: - Record review for residents #100, #101, and #102 revealed the following: Resident #100 admitted to the facility on 5/15/14. The record lacked documentation of a TB symptom screen and a two-step TB skin test.	S5230		

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S5230	Continued From page 48 Resident #101 admitted to the facility on 8/21/14. The record lacked a TB symptom screen. The record contained documentation of a TB skin test on 5/18/14 with results read on 5/21/14 and a second TB skin test on 5/28/14 with results read on 5/30/14. The form lacked documentation of the measurement of the skin test site on 5/21/14 and 5/30/14. The record lacked documentation of additional TB skin testing after admission to the facility. Resident #102 admitted to the facility on 7/31/14. The record contained a TB symptom screen dated 8/3/14 and a TB skin test on 8/3/14 and test result read on 8/5/14. The TB skin test form lacked documentation of the measurement of the skin test site. The record lacked documentation of additional TB skin testing. At 12:00 p.m. on 9/29/14, operator confirmed the lack of TB testing of the residents according to the department guidelines. Review of employee files at 3:20 p.m. on 9/29/14 revealed the following: Certified employee #D hired 8/4/14 with lack of a TB symptoms screen and TB skin testing. Certified employee #E hired 8/3/14 with TB symptom screen dated 8/3/14. The file contained documentation of a TB skin test 8/3/14 and result read on 8/5/14 but no result documented. Certified employee #F hired 7/18/14 with TB symptom screen 5/28/14 and TB skin test on 5/28/14. The form contained documentation of result read on 5/30/14 but lacked documentation of the result.	S5230		

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S5230	Continued From page 49 Certified employee #C hired 8/8/14 with a TB skin test completed on 7/30/14 and result documented on 8/1/14. The record lacked documentation of a second TB skin test. Licensed nurse #A hired 7/24/14 with documentation of TB symptom screen 7/24/14. The file lacked documentation of a two-step TB skin test. Registered nurse #B hired 5/15/14 with lack of a TB symptom screen and two-step TB skin testing. Operator confirmed the lack of TB testing of the employees according to the department guidelines. For residents #100, #101, and #102 and 6 employees, the operator 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		
S5251 SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of 5 residents. The sample included 3 residents. Based on record	S5251		

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review and interview for 2 (#102 and #100) of 3 residents sampled, the operator and licensed nurse failed to ensure each resident's record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.

Findings included:

- Record review for resident #102 revealed an admission date of 7/31/14. The record contained an information sheet from the assisted living facility where resident previously lived that listed diagnoses of chronic pain, hypertension, asthma, allergic rhinitis, and osteoarthritis.

Review of the progress notes revealed an entry by licensed nurse #A dated 9/18/14 that resident was verbally aggressive and trying to physically intimidate staff with cane. Licensed nurse #A documented he/she received an order from a medical care provider to send resident for a mental health evaluation and treatment if indicated. Licensed nurse #A documented resident was transported to hospital. The entry lacked the time of the incident and the time resident left the facility.

During an interview at 1:00 p.m. on 9/30/14, licensed nurse stated the time of the incident was around 7:30 p.m. to 8:00 p.m. Licensed nurse #A confirmed the documentation lacked a time of occurrence.

During an interview at 2:00 p.m. on 9/29/14, resident #102 stated that approximately 2 weeks after admission to the facility he/she received a burn to the back of left hand caused by hot water. Resident #102 stated he/she showed the burn to

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S5251	Continued From page 51	S5251		

the operator.

The resident's record lacked documentation of the resident's report of a burn to left hand.

At 5:00 p.m. on 9/29/14, operator stated he/she was aware of the resident's report of a burn to hand. Operator stated he/she did not do anything since he/she did not see a break in skin or redness.

The operator and licensed nurse failed to ensure resident #102's record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.

- Record review for resident #100 revealed an admission date of 5/15/14 and diagnoses of cerebral atrophy, Alzheimer's disease, osteoarthritis, and hypertension.

The progress notes contained an entry dated 8/2/14 at 4:00 p.m. by a certified medication aide that resident had a small sore on bottom and nurse came today and got an order for Duoderm to heal resident's bottom. The record lacked documentation of a wound assessment by the licensed nurse when staff discovered the wound.

The progress notes contained an entry by licensed nurse #A dated 8/10/14 that staff called to report resident rolled out of bed. Licensed nurse #A instructed staff to place resident in wheelchair and nurse would come to assess resident. The entry by licensed nurse #A lacked documentation of the time staff notified nurse, the time resident rolled out of bed, and the time nurse assessed the resident.

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S5251	Continued From page 52 The licensed nurse failed to ensure resident #100's record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.	S5251		
S5257 SS=F	26-42-102 (c) Staff Qualifications RN available (c) A registered professional nurse shall be available to provide supervision to licensed practical nurses, pursuant to K.S.A. 65-1113 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(c) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and interview for all residents, the operator failed to ensure a registered was available to provide supervision to licensed practical nurses, pursuant to K.S.A. 65-1113 and amendments thereto. Findings included: - During an interview at 4:30 p.m. on 9/24/14, operator stated licensed nurse #A was a licensed practical nurse and came to the facility 3 times a week and was on call for residents' unscheduled needs. Operator stated registered nurse #B terminated employment with the facility last month and he/she had just hired a registered nurse to start 9/30/14.	S5257		

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S5257	Continued From page 53 Review of the personnel list completed by the operator revealed registered nurse #B with hire date of 5/15/14 and licensed nurse #A hired on 7/24/14. At 3:00 p.m. on 9/25/14, licensed nurse #A stated he/she was not supervised by a registered nurse since he/she began working for the facility. Telephone interview with registered nurse #B at 12:55 p.m. on 9/29/14, who stated he/she worked for the facility for a very short time starting approximately 2 weeks after the facility opened and terminated in July 2014. Registered nurse #B stated he/she did not supervise a licensed practical nurse while employed by the facility. For all residents, the operator failed to ensure a registered was available to provide supervision to licensed practical nurses, pursuant to K.S.A. 65-1113 and amendments thereto.	S5257		
S5300 SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer	S5300		

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S5300	Continued From page 54 medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and interview for 2 (#102 and #101) of 3 residents sampled, the operator failed to ensure that all medications and biologicals were administered to each resident in accordance with a medical care provider's written order. Findings included: - Record review for resident #102 revealed an admission date of 7/31/14. The record contained an information sheet from the assisted living facility where resident previously lived that listed diagnoses of chronic pain, hypertension, asthma, allergic rhinitis, and osteoarthritis. The functional capacity screen dated 7/31/14 indicated the resident was unable to perform management of medications and medical treatments. The NSA dated 7/29/14 documented facility management of medications. Review of the 9/1/14 through 9/30/14 medication administration record revealed certified medication aides administered the following medications to the resident: Miralax powder (laxative) 17 grams daily Atenolol (anti-hypertensive) 25 milligrams (mg)	S5300		

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S5300	Continued From page 55 daily Klor-Con ER (potassium supplement) 8 milliequivalent daily Furosemide (diuretic) 20 mg daily Warfarin (anti-coagulant) 7.5 mg every day except Wednesday Warfarin 5 mg 1 tablet on Wednesday Hydrocodone/APAP 10/325 (for pain relief) 1 tablet 3 times a day Cranberry (to prevent urinary tract infection) 400 mg 1 capsule 3 times daily Hydrocodone/APAP 10/325 1 tablet daily as needed Debrox solution (to clear wax from ears) as needed Calmoseptine ointment (to relieve skin irritation from incontinence) topical as needed Imodium 2 mg tablet as needed to treat diarrhea Dulcolax (constipation) 10 mg suppository as needed Milk of magnesia (constipation) 30 milliliters as needed Tylenol 325 mg 2 tablets every 4 hours as needed for pain or elevated temperature Tramadol 50 mg 1 tablet every 8 hours as needed for pain The resident's record lacked written orders signed by the medical care provider for the medications administered to resident #102. At 3:05 p.m. on 9/25/14, licensed nurse #A confirmed the resident record lacked written orders signed by the medical care provider for resident to receive the above medications. At 12:00 p.m. on 9/29/14, the operator confirmed the resident record lacked written orders signed by the medical care provider for the medications administered to the resident.	S5300		

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S5300	Continued From page 56 The operator failed to ensure that all medications were administered to resident #102 in accordance with a medical care provider's written order. - Record review for resident #101 revealed an admission date of 8/21/14 and diagnoses of skull fracture with subarachnoid hemorrhage, hypertension, and dysphagia. The functional capacity screen dated 8/21/14 indicated the resident was unable to perform management of medications and medical treatments. The NSA dated 8/21/14 documented facility management of medications and medical treatments. Comparison of the written and signed medical care provider's orders and the 9/1/14 through 9/30/14 medication administration record revealed the resident did not receive Duoneb (to treat symptoms of chronic obstructive pulmonary disease) 0.5/3.0 solution, 1 vial, per nebulizer at 8:00 a.m. and 6:00 p.m. The medication record contained an entry and the resident record contained a written and signed medical care provider's order for Albuterol 0.83 milligrams/milliliter, 1 vial per nebulizer every 2 hours as needed for bronchospasms. The medication administration record did not indicate the resident had needed the breathing treatment for bronchospasms 9/1/14 through 9/25/14. At 4:45 p.m. on 9/29/14, certified medication aide #E confirmed resident #101 did not receive breathing treatment as ordered. Certified medication aide #E stated resident did not have a	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	C 10/06/2014

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S5300	Continued From page 57 nebulizer to receive breathing treatments. The operator failed to ensure that medications were administered to resident #101 in accordance with a medical care provider's written order.	S5300		
S5316 SS=F	26-42-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced	S5316		

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S5316	Continued From page 58 by: KAR 26-42-205(i)(1)(A)(B)(2)(A)(B)(C)(D) The facility reported a census of 5 residents. The sample included 3 residents. Based on interview, observation, and record review for all residents, the operator failed to develop and implement a policy and procedure for the accountability and disposition of all medications that included records maintained by licensed nurses and medication aides of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation; records of the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by two licensed nurses or a licensed nurse and a licensed pharmacist; and records of the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by two licensed nurses, a licensed nurse and a medication aide, a licensed nurse and a licensed pharmacist, or a medication aide and a licensed pharmacist. Findings included: - At 4:35 p.m. on 9/24/14, certified medication (CMA) #E unlocked the medication storage cabinet and removed a box of medications for resident #101 and stated a family member brought these medications when the resident moved to the facility (8/21/14) and stated the medications needed to be destroyed since resident did not receive the medications. The box contained the following: Calcium 500 milligrams (mg) with vitamin D 3 bottles Isopto Tears 5 bottles	S5316		

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S5316	Continued From page 59	S5316		

Brimonidine eye drops 1 bottle
Ibuprofen 800 mg tablets 1 bottle
Atorvastatin 80 mg 2 bottles
Etodolac 40 mg
Abilify 5 mg 1 box
Amlodipine 10 mg 1 partial bottle
Gabapentin 400 mg partial bottle
Finesteride 5 mg 1 bottle
Senna lax tablets with expiration date of 3/2012
Aspirin 325 mg partial bottle

CMA #E removed the following medications, packaged in bubble packs, resident #103 no longer received:
Risperidone 1 mg with 24 half-tablets
Seroquel 100 mg with 6 tablets
Risperdal 1 mg with 5 half tablets
Atorvastatin 20 mg with 6 tablets
Potassium 10 milliequivalents 12 tablets

The resident roster indicated the facility provided medication management to all 5 residents.

At 4:50 p.m. on 9/24/14, the operator stated did not have a written policy and procedure for the destruction of outdated or discontinued medications.

For all residents, the operator failed to develop and implement a policy and procedure for the accountability and disposition of all medications that included records maintained by licensed nurses and medication aides of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation; records of the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by two licensed nurses or a licensed nurse and a licensed

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S5316	Continued From page 60 pharmacist; and records of the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by two licensed nurses, a licensed nurse and a medication aide, a licensed nurse and a licensed pharmacist, or a medication aide and a licensed pharmacist.	S5316		