STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N085012	A. BUILDING: _____ B. WING _____	08/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLECREST RETIREMENT COMMUNITY	1501 EAST MAGNOLIA RD SALINA, KS 67401

(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 are the result of a Licensure Resurvey at the above named Assisted Living Facility in Salina, Kansas on 8/19/14 and 8/20/14. Complaint #77240 also investigated.	S 000		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The census equalled 44 the sample included three Residents and two focused reviews. Based on interviews and reviews of records, for one of three sampled (#185), the Operator failed to ensure all medications and biologicals were administered to that Resident in accordance with the medical care provider's written order.	S3200		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N085012	A. BUILDING: _____ B. WING _____	08/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLECREST RETIREMENT COMMUNITY	1501 EAST MAGNOLIA RD SALINA, KS 67401

(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
S3200	Continued From page 1 Findings included: - Review of record revealed #185 admitted to facility 6/20/13 with diagnoses of Hypertension, Hyperlipidemia, Cerebrovascular accident, Diabetes II, Gastroesophageal reflux disease, and Glaucoma. The current functional capacity screen (FCS) of 3/05/14 assessed #185 unable to perform (3) medication and treatment management. The current negotiated service agreement (NSA) of 3/05/14 documented facility staff to administer all medications and treatments. Comparison of the current August 2014 MAR (medication administration record) with written, signed physician orders revealed a discrepancy: Signed physician's order of 6/18/14 documented: Latanoprost 0.005% apply one drop OD (left eye) every day MAR documented order/administration as: Latanoprost 0.005% apply one drop both eyes one time daily On 8/20/14 at 1:20pm, Director of Nursing (DON) confirmed the order on the MAR transcribed incorrectly according to the written physician's order... stated when the orders added to the computer system on 7/18/14, transcribed incorrectly... audit also missed the discrepancy... will be doing a medication error report. The Operator failed to ensure all medications and biologicals administered to #185 in accordance with the medical care provider's written order.	S3200		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N085012	A. BUILDING: _____ B. WING _____	08/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLECREST RETIREMENT COMMUNITY	1501 EAST MAGNOLIA RD SALINA, KS 67401

(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
S3261	Continued From page 2 (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 26-41-105(f)(11) The census equalled 44 the sample included three Residents, with two focused reviews completed. Based on interviews and reviews of records for one of two focused reviews (#180), the Operator failed to ensure the medical record contained documentation of all incidents, symptoms, and other indications of illness, including the date, time of occurrence, action taken, and results of the action. Findings included: - Review of record revealed #180 admitted to facility 8/22/12 with diagnoses of Dementia, Osteoporosis, Hyponatremia, Hypertension, and recurrent Left ear infection. The current functional capacity screen (FCS) assessed #180 in need of physical assistance (2) with bathing; in need of supervision (1) with dressing; unable to perform (3) medication and treatment management; with cognitive impairment as (3) short term memory, memory recall, and decision making problems. The current negotiated service agreement (NSA) documented facility staff to provide services to meet these identified needs. The medical record contained "Progress Notes" (PN) entry of 6/30/14 at 1700, that documented	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N085012	A. BUILDING: _____ B. WING _____	08/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLECREST RETIREMENT COMMUNITY	1501 EAST MAGNOLIA RD SALINA, KS 67401

(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
S3261	Continued From page 3 #180 left facility with family member, moving to another facility... medications sent with Resident... alert and confused... ambulates with walker... The medical record lacked information to indicate if the Resident or family presented notice of intent to leave, or if the facility requested #180 leave. On 8/20/14 at 11:55am, Operator stated we did not give #180 or family a notice of discharge... we, myself and DON (Director of Nursing) did have a conversation with family member regarding increasing care needs of #180... the family member provided a notice of intent to leave a few days later... not sure of the date of our conversation, the nurses usually document PN... Operator provided letter from family member for review dated 6/20/14: Per our conversation on 6/17/14, you told me that my parent #180 needed to vacate his/her apartment at facility. He/She will be moving on 6/30/14 to another facility. On 8/20/14 at 12:17pm, DON stated we met with family member and Resident #180 to discuss care options... we did not ask #180 to move but family member perceived conversation that we kicked him/her out... determined we had our discussion on 6/17/14 but no documentation in the medical record of the conversation, the results of the conversation, actions taken, or the results of the actions... The Operator failed to ensure the medical record of #180 contained documentation of all incidents, symptoms, and other indications of illness, including the date, time of occurrence, action taken, and results of the action.	S3261		