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	B087201	A. BUILDING: _____ B. WING _____	R 07/09/2014

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KEEPSAKE KOTTAGE	8801 W BEKEMEYER ST WICHITA, KS 67212

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{S 000}	INITIAL COMMENTS The following citations represent the findings of a revisit for correction order 14-56 of the above home plus facility on 7/8/14 and 7/9/14.	{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) The facility reported a census of 4 residents. Based on record review and interview for all residents, the operator/certified nursing assistant (CNA) failed to inform each resident or the resident's legal representative, in writing at the time of admission, of the state statutes related to	{S 230}		

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

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{S 230}	Continued From page 1 advance medical directives. Findings included: - During an interview at 12:10 p.m. on 7/8/14, the operator/CNA stated he/she was working on written information to give to residents regarding advanced directives. The operator/CNA provided a Durable Power of Attorney for Health Care blank form and an information sheet "Frequently asked questions about a do not resuscitate (DNR) directive and DNR order." Operator/CNA stated he/she could not find the information he/she printed from the internet regarding a living will. For all residents, the operator/CNA failed to inform each resident or the resident's legal representative, in writing at the time of admission, of the state statutes related to advance medical directives.	{S 230}		
{S5080} SS=D	26-42-201 (a) (b) Functional Capacity Screen on Admission (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.	{S5080}		

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{S5080}	Continued From page 2 This REQUIREMENT is not met as evidenced by: KAR 26-42-201(b) The facility reported a census of 4 residents. The sample included 3 residents. Based on record review and interview for 1 (#1003) of 3 residents sampled, the operator/certified nursing assistant (CNA) failed to ensure a licensed nurse assessed the resident whose functional capacity screen (FCS) indicated the need for health care services. Findings included: - Record review for resident #1003 revealed an admission date of 2/12/14 and diagnoses of atrial fibrillation, congestive heart failure, hypertension, and urinary retention. The FCS dated 2/12/14 and signed as completed by the operator/CNA indicated the resident required supervision with bathing; supervision of the management of medications and treatments; and experienced impaired short-term memory, decision making, and memory recall. The FCS contained documentation that the resident had a urinary catheter. The FCS lacked evidence that a licensed nurse completed an assessment of resident #1003. The nurse's notes contained documentation by an APRN (advanced practice registered nurse) on 3/16/14 and 4/8/14 that the APRN changed the resident's indwelling urinary catheter. The	{S5080}		

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{S5080}	Continued From page 3 resident service plan dated 2/12/14 and completed by the operator/CNA documented the services of staff to drain/empty catheter bag as needed and nurse to change catheter one time a month. The record contained documentation of medications administered by certified medication aides. At 12:25 p.m. on 7/8/14, the operator/CNA stated facility certified medication aides administered medications to the resident and a hospice nurse performed monthly urinary catheter change. Operator/CNA confirmed the licensed nurse did not complete an assessment of the resident at the time of the FCS. The operator/CNA failed to ensure a licensed nurse assessed resident #1003 whose functional capacity screen indicated the need for health care services.	{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 4 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 4 residents. The sample included 3 residents. Based on record review and interview for 2 (#1003 and #1002) of 2 residents receiving services from an outside provider, the operator/ certified nursing assistant (CNA) failed to ensure the development of a written negotiated service agreement (NSA) for each resident that contained a description of services the resident would receive, the identification of the provider of each service, and the party responsible for payment when the service was provided by an outside resource. Findings included: - Record review for resident #1003 revealed an admission date of 2/12/14 and diagnoses of atrial fibrillation, congestive heart failure, hypertension, and urinary retention. The functional capacity screen dated 2/12/14 and signed as completed by the operator/CNA indicated the resident required supervision with bathing; supervision of the management of medications and treatments; and experienced impaired short-term memory, decision making, and memory recall. The functional capacity screen contained documentation that the resident had a urinary catheter. The record contained a form with the name of a hospice provider and an admission date to hospice services 4/24/14.	{S5105}		

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{S5105}	Continued From page 5 The nurse's notes contained documentation by an APRN (advanced practice registered nurse) on 3/16/14 and 4/8/14 that the APRN changed the resident's indwelling urinary catheter. The APRN documented in the nurse's notes 5/27/14 that urine had a foul odor and hospice nurse obtained a urine specimen for urinalysis. The resident service plan dated 2/12/14 and completed by the operator/CNA documented the services of staff to drain/empty catheter bag as needed and nurse to change catheter one time a month and that resident self-administered medications. The record contained monthly medication administration records with documentation that certified medication aides administered medications to the resident. The NSA signed by the resident's family member, the operator/CNA, and the APRN on 2/12/14 lacked a description of facility management of medications and the services provided by hospice. The NSA lacked the name of the hospice provider and the party responsible for payment of hospice services. During an interview at 12:25 p.m. on 7/8/14, the operator/CNA stated facility certified medication aides administered medications to the resident and a hospice nurse performed monthly urinary catheter change. Operator/CNA confirmed the NSA lacked a description of these services, the name of the hospice provider, and the party responsible for payment of hospice services. The operator/CNA failed to ensure the development of a written NSA for resident #1003 that contained a description of services the resident would receive, the identification of the	{S5105}		

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{S5105}	Continued From page 6	{S5105}		

provider of each service, and the party responsible for payment when the service was provided by an outside resource.

- Record review for resident #1002 revealed an admission date of 2/12/14 and diagnoses of diabetes mellitus type II, heart disease, and generalized muscle weakness.

The functional capacity screen dated 2/12/14 indicated the resident required supervision with transferring and eating and physical assistance with bathing, dressing, toileting, mobility, and management of medications and treatments.

At 10:35 a.m. on 7/8/14, CNA #A stated hospice provided bathing services to the resident and hospice nurse provided wound care. CNA #A stated resident experienced vomiting and diarrhea this morning and a hospice nurse came to evaluate the resident.

The record contained an "Addendum to Care Plan" that documented on 4/23/14 that hospice services started and documented the name of the provider.

Review of the NSA signed by the APRN on 7/2/14 revealed the lack of the name of the hospice providing services, a description of services provided by hospice, and the party responsible for payment of hospice services.

At 12:30 p.m. on 7/8/14, the operator/CNA stated a hospice aide visited to provide bathing assistance and a nurse visited 2 times a week to assess the resident. The operator/CNA confirmed the resident's NSA lacked a description of the services provided by hospice, the name of the hospice, and the party responsible for

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{S5105}	Continued From page 7 payment of hospice services. The operator/CNA failed to ensure the development of a written NSA for resident #1002 that contained a description of services the resident would receive, the identification of the provider of each service, and the party responsible for payment when the service was provided by an outside resource.	{S5105}		
{S5161} SS=D	26-42-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(d) The facility reported a census of 4 residents. The sample included 3 residents. Based on record review and interview for 1 (#1003) of 3 residents sampled, the operator/certified nursing assistant (CNA) failed to ensure the negotiated service agreement (NSA) contained the name of the licensed nurse responsible for the implementation and supervision of the plan. Findings included: - Record review for resident #1003 revealed an admission date of 2/12/14 and diagnoses of atrial fibrillation, congestive heart failure, hypertension, and urinary retention.	{S5161}		

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{S5161}	Continued From page 8 The functional capacity screen dated 2/12/14 and signed as completed by the operator/CNA indicated the resident required supervision with bathing; supervision of the management of medications and treatments; and experienced impaired short-term memory, decision making, and memory recall. The functional capacity screen contained documentation that the resident had a urinary catheter. The resident service plan dated 2/12/14 and completed by the operator/CNA documented the health care services of staff to drain/empty catheter bag as needed and nurse to change catheter one time a month and that resident self-administered medications. The record contained monthly medication administration records with documentation that certified medication aides administered medications to the resident. The NSA signed by the resident's family member, the operator/CNA, and the APRN on 2/12/14 lacked the name of the licensed nurse responsible for the implementation and supervision of the plan. At 12:25 p.m. on 7/8/14, the operator/CNA confirmed the NSA lacked the name of the licensed nurse responsible for the implementation and supervision of the plan. The operator/CNA failed to ensure the NSA for resident #1003 contained the name of the licensed nurse responsible for the implementation and supervision of the plan.	{S5161}		
{S5215} SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education	{S5215}		

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{S5215}	Continued From page 9 (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 (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)(3) The facility reported a census of 4 residents. The sample included 3 residents. Based on interview for all employees, the operator/certified nursing assistant (CNA) failed to ensure a quarterly review of the facility's entire emergency management plan with employees in order to ensure disaster and emergency preparedness. Findings included: - At 10:05 a.m. on 7/8/14, CNA #A stated the meeting to review the emergency management plan was cancelled last Thursday (7/3/14) and rescheduled for later. At 11:10 a.m. on 7/8/14, the operator/CNA stated he/she reviewed part of the emergency	{S5215}		

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{S5215}	Continued From page 10 management plan with employees on 6/6/14 with an in-service scheduled for 7/18/14 to review the plan with employees. Operator stated the facility opened on 2/1/14. The operator/CNA failed to ensure a quarterly review of the facility's entire emergency management plan with employees in order to ensure disaster and emergency preparedness.	{S5215}		
{S5315} SS=F	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be	{S5315}		

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{S5315}	Continued From page 11 stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h)(1) The facility reported a census of 4 residents. The sample included 3 residents. Based on record review, interview, and observation for all residents, the operator/certified nursing assistant (CNA) failed to ensure only licensed nurses and certified medication aides (CMA) had access to the stored medications and biologicals. Findings included: - At 10:00 a.m. on 7/8/14 CNA #A stated he/she was the only employee in the facility to care for residents until 7:00 p.m. this evening. CNA #A stated the CMA who worked 7:00 p.m. to 7:00 a.m. shift stayed over this morning to administer the 8:00 a.m. medications to residents. CNA #A stated medications were stored in a medication cart and he/she did not have access to resident medications. Observed a locked medication cart in the dining area. At 12:10 p.m. on 7/8/14, the operator/CNA stated he/she had the key to the medication cart because he/she was afraid a CMA might lose the key the CMA carried during his/her shift. Observed operator/CNA go to the office and remove a key ring with keys from the lock on the	{S5315}		

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{S5315}	Continued From page 12 file cabinet. Operator/CNA stated that the keys to the medication storage were on this ring. Operator/CNA showed that the key ring with the keys was usually placed in a mesh basket on top of the desk in the office. Observed that the door to the office did not have a door knob. Operator/CNA stated the door knob and lock was being replaced since door did not lock securely. Operator/CNA confirmed he/she was not a certified medication aide and anyone could have access to the keys when stored in the unlocked office. Operator/CNA stated that when a CMA was relieved by a CNA, the off-going CMA placed the medication keys in a location only CMAs knew about. Operator/CNA stated he/she did not know the location but knew it was not in a locked location. The operator/CNA failed to ensure only licensed nurses and CMAs had access to stored medications and biologicals.	{S5315}		