STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087201	A. BUILDING: _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEEPSAKE KOTTAGE	8801 W BEKEMEYER ST WICHITA, KS 67212

(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 Home Plus Facility in Wichita, Kansas on 6/16/14, 6/17/14, 6/18/14, and 6/19/14.	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)(1)(2)(c) The census equalled four the sample included three Residents. Based on interviews and reviews of records, for three of three sampled (#185, #189, and #187), the Operator failed to ensure the implementation of facility policies and	S 230		

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

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S 230	Continued From page 1 procedures that documented: Facility to inform the Resident or their representative in writing of the state statutes related to advanced directives, and Facility to provide copies of Resident Rights, facility policies and procedures for advanced directives, and grievance policy prior to signing of admission agreement. Findings included: - Review of record revealed #185 admitted to facility 5/07/14 with diagnoses of Convulsions, History of brain malignancy, Hyperlipidemia, Depressive disorder, Infection of multiple sites, Malaise and fatigue. The binder of the medical chart contained labeling Full Code. The medical record lacked evidence written information provided to #185 prior to signing admission agreement, that included state statute information related to advanced directives, Resident rights, and grievance policy. The medical record for #185 did contain a Living Will and a Durable Power of Attorney for Health Care. - Record review revealed #189 admitted to facility 02/01/14 with diagnoses of Hypertension, Hernia inguinal, Delusional disorder, Depressive disorder, Malnutrition, Dementia, Anxiety, and Chronic obstructive pulmonary disease. The binder of the medical chart contained labeling Full Code. The medical record lacked evidence written information provided to #189 prior to signing admission agreement, that included state statute information related to advanced directives, Resident rights, and grievance policy. The medical record for #189 did contain a General Durable Power of Attorney.	S 230		

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S 230	Continued From page 2 - Review of record revealed #187 admitted to facility 02/12/14 with diagnoses of Diabetes, Abnormal gait, Hypertension, Atherosclerotic heart disease, Malaise and fatigue, Syncope and collapse, and Urinary tract infection. The binder of the medical chart contained labeling "DNR". A DNR form in record completed at time of admission documented "witnessed" by Operator/CNA (certified nurse aide). On 6/16/14 at 4:05pm, Operator/CNA stated I just ask them if they have one (advanced directive)... I don't have anything that I actually give them in writing... On 6/16/14 Operator/CNA provided copies of facility policies, procedures, and corresponding blank "acknowledgment of receipt"signature forms from facility policy manual. These forms related to receipt of Grievance policy, Resident Rights, and Advanced Directive information. Review of the facility admission agreement revealed statement on front page: Facility has provided a copy of its policy regarding Resident Rights, Advanced Medical Directives, and Grievances... before presenting this Admission Agreement... Review revealed statement at section "III" of admission agreement: All Residents will be informed of their rights regarding Durable Power of Attorney for Health Care and Advanced Directives... any Resident who has already initiated an Advanced Medical Directive... will be asked to furnish a copy to facility at time of admission... On 6/16/14 at 5:30pm, Operator/CNA stated I can't find signature pages for Resident rights and Grievance policy... but I remember going over	S 230		

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S 230	Continued From page 3 that with them... On 6/17/14 at 10:10am, Operator/CNA stated not able to find any forms or signature pages, remember going over them... no copies in files... The Operator failed to demonstrate he/she implemented facility policies and procedures for #189, #187, and #185, related to informing all Residents in writing at time of admission, of the state statutes regarding Advanced Medical Directives, Resident Rights, and facility Grievance policy.	S 230		
S5028 SS=D	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the 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.	S5028		

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S5028	Continued From page 4 (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) The census equalled four the sample included three Residents. Based on interviews and reviews of records, for one of one sampled who experienced an unwitnessed fall with injury, when attempting to complete toileting independently, although assessed to need physical assistance (#187), the Operator failed to ensure: Each allegation of neglect or abuse reported to the Department within 24 hours; Each allegation thoroughly investigated within five working days of the initial report; A written record maintained of each investigation to rule out abuse or neglect Findings included; - Review of record revealed #187 admitted to facility 02/12/14 with diagnoses of Diabetes, Abnormal gait, Hypertension, Atherosclerotic heart disease, Malaise and fatigue, Syncope and collapse, and Urinary tract infection. Current functional capacity screen of 02/12/14 assessed #187 in need of physical assistance with bathing, dressing, toileting, mobility, medication and treatment management; in need of supervision with eating and transfers; with bladder incontinence, and with short term memory, memory recall, and decision making impairments.	S5028		

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S5028	Continued From page 5 Current negotiated service agreement of 02/12/14 documented facility staff to provide assistance for these needs as "included" services. Current health service plan (HSP) of 02/14/14 documented facility staff to "assist as needed" with dressing, assist with bathing, stand by assist when using walker, assist with medications... Incontinent of bowel and bladder, more often at night, has accidents sometimes... On 6/16/14 at 3:30pm, observed Certified staff #A use gait belt and verbal prompts to #187 in standing from couch, to turn, sit back in transport chair to go to bathroom... #A stated #187 knows when he/she needs to go but can't always tell us in time... we assist #187 with most everything... dressing, toileting, transfers... Hospice comes and gives bath three times week... Fall Incident Report documented #187 experienced unwitnessed fall on 5/27/14 at 4:30am... apparently attempted to get out of bed to bedside commode... on stomach, head turned sideways, on right arm, fell forward into closet area... skin tears on left cheek, left clavicle area, small tear at left eyebrow area, carpet burns on both knees, small red spot on left arm above elbow... certified staff on duty found #187 on floor, called facility nurse, and completed incident report... The medical record lacked an investigation of this unwitnessed fall with injury, when #187 attempting to toilet self, although assessed to need assistance, and documented on NSA to get staff assistance with toileting. The medical record lacked evidence this incident reported to the Department, with the intention to investigate the circumstances to rule out potential abuse or neglect.	S5028		

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S5028	Continued From page 6 The facility policy and procedure for Abuse, Neglect, Exploitation of Resident Definitions included: Neglect means the failure or omission by caretaker to provide goods or services reasonable necessary to ensure safety and well being and avoid physical harm... The facility policy and procedure for Abuse, Neglect, & Exploitation Prevention included: 6. The Home will ensure that all allegations of abuse, neglect or exploitation (ANE) are investigated and reported immediately to the Operator and to Department... 7. The Home will provide evidence that all alleged violations are thoroughly investigated and take measures to prevent further potential ANE... 8. The Home will report the results of all facility investigations... 9. The Home will maintain a written record of all investigations... The facility policy and procedure for Abuse, Neglect, & Exploitation Investigation Procedure included: When an allegation of ANE has been made... Operator will be contacted immediately... a facility incident report shall be completed by the Operator... A review of the incident and subsequent follow up will be documented in the Resident's medical record by Operator and Facility Licensed Nurse... Department Complaint Division will be contacted and a report given... All attendant paperwork will be completed and submitted to the Complaint Division within five working days... On 6/17/14 at 12:10pm, Operator/CNA (certified nurse aide) stated no written investigation to rule out neglect or abuse completed... no reporting to	S5028		

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S5028	Continued From page 7 Department... did put corrective interventions into place after this fall, but these new interventions/services not added to the NSA or HSP. The Operator failed to ensure each potential allegation of ANE for #187 reported to the Department within 24 hours, thoroughly investigated within five working days of the initial report, and failed to maintain a written record of each investigation to rule out abuse or neglect.	S5028		
S5080 SS=F	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. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(b)	S5080		

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S5080	Continued From page 8 The census equalled four the sample included three Residents. Based on observations, interviews, and reviews of records, for three of three sampled (#187, #185, and #189), the Operator failed to ensure a licensed nurse assessed any Resident whose functional capacity screening indicated the need for health care services. Findings included: - Review of record revealed #187 admitted to facility 02/12/14 with diagnoses of Diabetes, Abnormal gait, Hypertension, Atherosclerotic heart disease, Malaise and fatigue, Syncope and collapse, and Urinary tract infection. The current FCS of 02/12/14 documented #187 in need of health care services (bathing, dressing, toileting, mobility, medication and treatment management); with need of supervision for transfers and eating; with bladder incontinence; with impaired communication; and with short term memory, memory recall, and decision making impairments. This FCS, signed by Operator/CNA (certified nurse aide), lacked evidence a licensed nurse completed the assessment of #187. On 6/16/14 at 1:55pm, Operator/CNA (certified nurse aide) stated I have completed all the FCS's... I know it can be me or the nurse... By observation on 6/16/14 at 3:30pm, Certified staff #A assisted #187 up off couch with verbal prompts and gait belt... into wheelchair... assisted #187 mobility and toileting. By interview on 6/16/14 at 3:30pm, Certified staff #A stated #187 in need of staff physical assistance (health care needs) with most everything... bathing, dressing, toileting, transfers,	S5080		

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S5080	Continued From page 9 mobility, incontinence, medications... On 6/16/14 at 6:40pm Operator/CNA and Facility Nurse ARNP (advanced registered nurse practitioner) #D reviewed FCS manual... stated not aware language of FCS manual and regulation specified licensed nurse to complete FCS when health care services needed. On 6/17/14 at 11:20am, Operator/CNA confirmed #187 required physical assistance with health care... needs cuing and staff to dry feet etc. for bathing process... we help with pants when dressing, we walk with him/her to toilet and do the perineal cleaning after toilet...sometimes help up off the couch or chair depends on the day... we walk beside him/her to ensure steadiness... we administer all medications and treatments... The Operator failed to ensure a licensed nurse completed an assessment of #187 when FCS indicated health care services needed. - Review of record revealed #185 admitted to facility 5/07/14 with diagnoses of Convulsions, History of brain malignancy, Hyperlipidemia, Depressive disorder, Infection of multiple sites, Malaise and fatigue. The current functional capacity screen (FCS) of 5/07/14 assessed #185 in need of health care service (treatment management). This FCS, signed by Operator/CNA (certified nurse aide), lacked evidence a licensed nurse completed the assessment of #185. On 6/16/14 at 1:55pm, Operator/CNA (certified nurse aide) stated I have completed all the FCS's... I know it can be me or the nurse...	S5080		

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S5080	Continued From page 10 On 6/16/14 at 3:25pm Certified staff #A assisted #185 out of chair and walked beside #185 to bathroom using gait belt. On 6/16/14 at 3:35pm Certified staff #A stated #185 needs my help... I took him/her to bathroom, continent of bowel, incontinent of bladder... we give his/her shower and do most dressing in the mornings...same with undressing in the evening... give medications... On 6/16/14 at 6:40pm Operator/CNA and Facility Nurse ARNP (advanced registered nurse practitioner) #D reviewed FCS manual... stated not aware language of FCS manual and regulation specified licensed nurse to complete FCS when health care services needed... Operator/CNA and ARNP #D went on to review the FCS for #185 stating #185 does need help with bathing, dressing, toileting, mobility, eating... for safety. The Operator failed to ensure a licensed nurse completed an assessment of #185 when FCS indicated health care services needed. - Record review revealed #189 admitted to facility 02/01/14 with diagnoses of Hypertension, Hernia inguinal, Delusional disorder, Depressive disorder, Malnutrition, Dementia, Anxiety, and Chronic obstructive pulmonary disease. The current FCS of 02/01/14 assessed #189 in need of health care services (bathing, medication and treatment management). This FCS, signed by Operator/CNA (certified nurse aide), lacked evidence a licensed nurse completed the assessment of #185. On 6/16/14 at 1:55pm, Operator/CNA (certified	S5080		

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S5080	Continued From page 11 nurse aide) stated I have completed all the FCS's... I know it can be me or the nurse... On 6/16/14 at 6:40pm Operator/CNA and Facility Nurse ARNP (advanced registered nurse practitioner) #D reviewed FCS manual... stated not aware language of FCS manual and regulation specified licensed nurse to complete FCS when health care services needed... On 6/17/14 at 10:30am, Operator/CNA stated #189 in need of medication and treatment management but not in need of bathing assistance... stated ARNP #D signed the FCS last night, but did not make any corrections to the assessment codes... it will need to be re-done. The Operator failed to ensure a licensed nurse completed an assessment of #189 when FCS indicated health care services needed.	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 12 payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a) The census equalled four the sample included three Residents. Based on observations, interviews, and reviews of records, for three of three sampled the Operator failed to ensure the development of a written negotiated service agreement (NSA) for each Resident that contained a description of the services the Resident will receive; and For two of two sampled with services by an outside provider (#187 and #185), the Operator failed to ensure the development of a written negotiated service agreement (NSA) for each Resident that identified the provider of each service; and identified the party responsible for payment if outside resources provide a service. Findings included: - Review of record revealed #187 admitted to facility 02/12/14 with diagnoses of Diabetes, Abnormal gait, Hypertension, Atherosclerotic heart disease, Malaise and fatigue, Syncope and collapse, and Urinary tract infection. Current functional capacity screen (FCS) of 02/12/14 assessed #187 in need of physical assistance with bathing, dressing, toileting, mobility, medication and treatment management; in need of supervision with eating and transfers; with bladder incontinence, and with short term memory, memory recall, and decision making impairments. FCS contained note at section VII "admitted with Home Health... PT/OT (physical therapy/occupational therapy).	S5105		

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S5105	Continued From page 13 Current NSA of 02/12/14 documented facility staff to provide assistance for these needs as "included" services. Current health service plan (HSP) of 02/14/14 documented facility staff to "assist as needed" with dressing, assist with bathing, stand by assist when using walker, assist with medications... Incontinent of bowel and bladder, more often at night, has accidents sometimes... On 6/16/14 at 3:30pm Certified staff #A stated Hospice comes in three times weekly to bathe #187... On 6/17/14 at 11:30am, Hospice staff observed visiting #187, reviewing medical record, and documenting in #187's medical record. The NSA lacked the outside service provider for OT/PT, the name of the company, and the payment source. The NSA lacked the outside service provider for Hospice, lacked the name of the company, and lacked the payment source. The HSP lacked services the PT/OT and Hospice to provide. On 6/16/14 at 4:40pm, Operator/CNA (certified nurse aide) stated #187 did not admit with Hospice... I was not aware that had to be on the NSA... they come in and do their stuff, we do our stuff... communicate back and forth a lot... The Operator failed to ensure an NSA developed for #187 that included a description of services to be provided, the names of outside service providers (Hospice and Home Health), and the source of payment for these outside providers. - Review of record revealed #185 admitted to	S5105		

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S5105	Continued From page 14 facility 5/07/14 with diagnoses of Convulsions, History of brain malignancy, Hyperlipidemia, Depressive disorder, Infection of multiple sites, Malaise and fatigue. Current functional capacity screen (FCS) of 5/07/14 assessed #185 in need of "supervision" (1) with bathing, dressing, toileting, transfers, mobility, eating, management of medications; in need of physical assistance (2) with management of treatments; with bladder incontinence; with falls/unsteadiness; and no assessment of cognitive status. Current NSA of 5/07/14 documented facility staff to provide assistance for these needs as "included" services. Current health service plan (HSP) documented facility staff supervision and assistance with gait belt as needed for mobility; staff assist with toileting; assist, cue/remind with self dressing; wash hair after breakfast in the shower; cut meat and provide lactose intolerant cheese... Medical Record contained 5/05/14 phone order that documented "dismiss to 'Facility Name' on 5/07/14 without medications with 'Company Name' Home Health (PT.OT.SS.AID.NRS)" On 6/16/14 at 6:45pm Operator and Facility Nurse stated we were all together when completed the Care Plan, Durable Power of Attorney for #185, Operator, Nurse... we didn't put Home Health services on the NSA or HSP... PT/OT ordered and started at time of admission... The Operator failed to ensure an NSA developed for #185 that included a description of services to be provided, name of the outside provider (Home Health), and the source of payment for the outside provider.	S5105		

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S5105	Continued From page 15 - Record review revealed #189 admitted to facility 02/01/14 with diagnoses of Hypertension, Hernia inguinal, Delusional disorder, Depressive disorder, Malnutrition, Dementia, Anxiety, and Chronic obstructive pulmonary disease. The current FCS of 02/01/14 assessed #189 in need of assistance with bathing, in need of supervision with dressing, toileting, transfers, mobility, medication and treatment management. The current 02/01/14 NSA documented facility staff to provide assistance for these needs as "included" services. By observation on 6/17/14 at 9:55am, #189 prepared to leave facility on an outing, as staff prepared sack lunch for Resident to take with him/her. On 6/17/14 at 9:55am, Operator/CNA (certified nurse aide) stated #189 goes to visit spouse several days a week... we agreed to transport #189 for these visits. By review, the NSA lacked this agreed upon service. On 6/17/14 at 9:55am, Operator/CNA stated we did not get that in the NSA... it was noted on the admission agreement. The Operator failed to ensure an NSA developed for #189 that included a description of the services to provided.	S5105		
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health	S5155		

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S5155	Continued From page 16 care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The census equalled four the sample include three Residents. Based on reviews of records and interviews, for one of three sampled with diagnosis requiring specific infection control precautions (#187), the Operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each Resident. Findings included: - Review of record revealed #187 admitted to facility 02/12/14 with diagnoses of Diabetes, Abnormal gait, Hypertension, Atherosclerotic heart disease, Malaise and fatigue, Syncope and collapse, and Urinary tract infection. Current functional capacity screen of 02/12/14 assessed #187 in need of physical assistance with bathing, dressing, toileting, mobility, medication and treatment management; in need of supervision with eating and transfers; with bladder incontinence, and with short term memory, memory recall, and decision making impairments. Current negotiated service agreement (NSA) of 02/12/14 documented facility staff to provide assistance for these needs as "included"	S5155		

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S5155	Continued From page 17 services. Current health service plan (HSP) of 02/14/14 documented facility staff to "assist as needed" with dressing, assist with bathing, stand by assist when using walker, assist with medications... Incontinent of bowel and bladder, more often at night, has accidents sometimes... Nurse's Notes of 4/24/14 documented "stool C-diff (clostridium difficile) positive, will start Flagyl 500mg (milligrams) by mouth three times daily... is now under Hospice, will have Hospice provide meds and administer." The NSA and HSP lacked documentation of licensed nurse provision or coordination of health care services to address the diagnoses of C-diff. According to 2012 Department Guidelines for the Prevention and Control of Clostridium Difficile in Long Term Care, specific isolation practices needed to be implemented and documented in the Resident's HSP. On /16/14 at 4:40pm, Operator/CNA (certified nurse aide) stated we had gowns and gloves... went over the risks with spouse and offered an empty room for spouse but declined... used Clorox solution per online source to clean everything... symptoms subsided after roughly two weeks... no nothing ever added to the care plan or the NSA... no specific plan used or infection control policy... The Operator failed to ensure the licensed nurse provided or coordinated the provision of needed health care services to #189 in regard to a diagnosis requiring specific infection control precautions.	S5155		
S5161 SS=F	26-42-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services	S5161		

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S5161	Continued From page 18 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 census equalled four the sample included three Residents. Based on interviews and reviews of records, for three of three sampled (#189, #187, and #185), the Operator 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: - Review of record revealed #185 admitted to facility 5/07/14 with diagnoses of Convulsions, History of brain malignancy, Hyperlipidemia, Depressive disorder, Infection of multiple sites, Malaise and fatigue. The current functional capacity screen (FCS) of 5/07/14 assessed #185 in need of health care services (medication and treatment management) and the current negotiated service agreement (NSA) of 5/07/14 documented facility staff to provide health care services (all services labeled "included"). The NSA contained a designated section on page 1 of 3 "Name of Licensed Nurse Responsible for Plan." This section remained blank. - Record review revealed #189 admitted to facility 02/01/14 with diagnoses of Hypertension, Hernia inguinal, Delusional disorder, Depressive disorder, Malnutrition, Dementia, Anxiety, and Chronic obstructive pulmonary disease. The	S5161		

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S5161	Continued From page 19 current FCS of 02/01/14 assessed #189 in need of health care services (bathing, medication and treatment management) and the current NSA of 02/01/14 documented facility staff to provide health care services (all services labeled "included"). The NSA contained a designated section on page 1 of 3 "Name of Licensed Nurse Responsible for Plan." This section remained blank. - Review of record revealed #187 admitted to facility 02/12/14 with diagnoses of Diabetes, Abnormal gait, Hypertension, Atherosclerotic heart disease, Malaise and fatigue, Syncope and collapse, and Urinary tract infection. The current FCS of 02/12/14 assessed #187 in need of health care services (bathing, dressing, toileting, mobility, medication and treatment management) and the current NSA of 02/12/14 documented facility staff to provide health care services (all services labeled "included"). The NSA contained a designated section on page 1 of 3 "Name of Licensed Nurse Responsible for Plan." This section remained blank. On 6/16/14 at 1:55pm, Operator/CNA (certified nurse aide) stated I have completed all the FCS's, NSA's, and Health Service Plans... I think the Nurse Practitioner has signed off on them... our facility nurse is ARNP (advanced registered nurse practitioner) #D... #D is not written on the NSA's as nurse responsible for health care services. The Operator failed to ensure the NSA's for #189, #187, and #185 contained the name of the licensed nurse responsible for the implementation and supervision of the plan.	S5161		

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S5171	Continued From page 20	S5171		
S5171 SS=D	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 census equalled four the sample included three Residents. Based on interview and reviews of record, for one of three sampled (#189), the Operator failed to ensure all health care services provided to Residents by qualified staff in accordance with acceptable standards of practice. Findings included: - Record review revealed #189 admitted to facility 02/01/14 with diagnoses of Hypertension, Hernia inguinal, Delusional disorder, Depressive disorder, Malnutrition, Dementia, Anxiety, and Chronic obstructive pulmonary disease. The current FCS of 02/01/14 assessed #189 in need of health care services (bathing, medication and treatment management) and the current NSA of 02/01/14 documented facility staff to provide health care services (all services labeled "included"). Admission information of 02/01/14 included an order for weekly weights, dated 01/21/14 on the MAR (medication administration record). The June 2014 MAR lacked any weights. Pharmacy drug regime review (Consultation Report) of 6/10/14 documented the weekly weights not being recorded. The Consultation	S5171		

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S5171	Continued From page 21 Report contained the signature of the Facility Nurse #D dated 6/16/14. On 6/1/14 at 9:50am, Facility Nurse #D stated my signature on the Consultation Report from pharmacy means I have read and acknowledged... and FYI (for your information) to me... typically I just sign them but do not make any changes... On 6/17/14 at 10:04am Operator/CNA (certified nurse aide) stated this morning's weight was 105... this number now written on the June 2014 MAR... we had been writing them elsewhere, so after Pharmacist's note, we looked up the weights and took weight today. Operator/CNA then furnished all weights available since admission: 3/23/14 weight 105 pounds, and 5/02/14 weight 104 pounds. Operator/CNA reported no other weights available. The record lacked any response or intervention by Facility Nurse #D in response to the failure to follow the admission order for weight weekly, and in response to the Pharmacist's report this service not documented. The Operator failed to ensure all health care services provided to #189 by qualified staff in accordance with acceptable standards of practice.	S5171		
S5195 SS=E	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.	S5195		

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S5195	Continued From page 22 (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 census equalled four the sample included three Residents. The facility provided meal services to all Residents. Based on observations and interview, for two of two kitchen observations, the Operator failed to ensure facility staff stored all food under safe and sanitary conditions, and in accordance with food safety guidelines. Findings included: - By observation on 6/16/14 at 1:00pm, in kitchen of facility next to sink, a one pound package of lean ground beef floated in a plastic bowl of cool water. By observation on 6/16/14 at 3:40pm, in kitchen of facility next to sink, the same one pound package of lean ground beef floated in the plastic bowl of cool water. The ground beef was soft and pliable. On 6/16/14 at 3:45pm, Certified staff #A stated to thaw meats I sometimes put them in the refrigerator the night before... or try to remember to tell other staff to put it in the refrigerator... otherwise I put it in cold water in a bowl to thaw. At this time Certified staff #A emptied the bowl of water and placed the ground beef in the refrigerator. By review of facility policy and procedure	S5195		

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S5195	Continued From page 23 provided, options for thawing of meat did not include a bowl of cold water on the kitchen counter... the policy and procedure directed thawing in cold running water or in the refrigerator. By review, Food Safety Guidelines also identified refrigerator thawing method or placing meat under 70 degree running water. The Operator failed to ensure dietary staff stored all food under safe and sanitary conditions and in accordance with facility policy and procedure.	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 (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)	S5215		

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S5215	Continued From page 24 The census equalled four the sample included three Residents. The facility identified nine employees. Based on interviews and reviews of records, for all Residents and all employees, the Operator failed to ensure quarterly reviews of the facility's emergency management plan to ensure disaster and emergency preparedness. Findings included: - On 6/16/14 at 2:20pm, Operator/CNA (certified nurse aide) reported facility opened 02/01/14. Operator provided documentation of one "Full evacuation/Fire Drill/Severe Weather Practice" held on 6/06/14. Operator stated no other reviews of the facility's emergency management plan completed with Residents and staff since facility opened. The Operator failed to ensure quarterly reviews of the facility's emergency management plan completed with Residents and employees to ensure disaster and emergency preparedness.	S5215		
S5300 SS=D	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	S5300		

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S5300	Continued From page 25 which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The census equalled four the sample included three Residents. The facility identified all Residents with facility managed medications. Based on interviews and reviews of records, for one of the three sampled with facility managed medications (#187), the Operator failed to ensure all medications administered to all Residents in accordance with written medical care provider orders, and in accordance with professional standards of practice. Findings included: - Review of record revealed #187 admitted to facility 02/12/14 with diagnoses of Diabetes, Abnormal gait, Hypertension, Atherosclerotic heart disease, Malaise and fatigue, Syncope and collapse, and Urinary tract infection. Current functional capacity screen of 02/12/14 assessed #187 in need of physical assistance with medication and treatment management. Current negotiated service agreement of 02/12/14 documented facility staff to provide medication and treatment management as an "included" service. Current health service plan (HSP) of 02/14/14 documented facility staff to assist with medications. Comparison of the current June 2014 MAR	S5300		

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S5300	Continued From page 26 (medication administration record) with current written medical care provider orders revealed discrepancies. MAR contained medication order: Q Tussin DM 10mg (milligrams)/5ml (milliliters) every 4 hours as needed for cough; the current 5/20/14 written order documented: Robitussin cough syrup 10ml every 6 hours prn (as needed) cough. MAR contained medication order: Albuterol sulfate 2.5mg/3ml use contents of one vial in nebulizer every 4-6 hours as needed as directed; the current 5/17/14 written order documented Albuterol breathing treatment per nebulizer PRN SOA (shortness of air)/cough. The record discrepancies indicated clarification not obtained from the medical care provider, when the orders received, in accordance with professional standards of practice. On 6/17/14 at 11:45am, Operator/CNA (certified nurse aide) and CMA (certified medication aide) #A confirmed the current written orders did not match directions on the current MAR... stated not sure why the medical care provider changed the written order... not sure why Facility Nurse did not ensure pharmacy printed new order on MAR. The Operator failed to ensure all medications and biologicals administered to #187 in accordance with written medical care provider orders, and in accordance with professional standards of practice.	S5300		
S5301 SS=E	26-42-205 (d) (3) Facility Administration of Medications (d) (3) A licensed nurse or medication aide shall perform the following:	S5301		

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S5301	Continued From page 27 (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(3) The census equalled four the sample included three Residents. The facility identified all Residents as receiving medication management. Based on observations and interviews, for one of three sampled (#187) and one non-sampled (#180), the Operator failed to ensure the CMA (certified medication aide) remained with the Resident until the medication placed next to them at the breakfast table was ingested. Findings included: - By observation on 6/17/14 at 9:30am, #187 and #180 sat at kitchen table eating breakfast... Certified Medication aide #A completed household tasks in nearby kitchen with attention shifted from Residents at the table. A clear medication portion cup sat between #187's plate	S5301		

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	B087201	A. BUILDING: _____ B. WING _____	06/19/2014

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S5301	Continued From page 28 and silverware on the right side of plate... the cup contained an assortment of tablets and capsules. A clear medication cup also sat next to #180's plate next to silverware. Residents continued to eat meal, with #180 swallowing medications in #180's plastic cup as CMA #A continued household tasks. #187 continued to eat breakfast, and plastic pill cup remained next to plate. On 6/17/14 at 9:30am, when asked about medications at table, CMA #A stated I set their pills by their plates because they like to take them as they finish eating... At this time CMA #A picked up plastic pill cup next to #187's plate and placed back in the locked medication cart, explained to #187 I will bring them back when you are finished eating. At 9:40am, #A returned plastic pill cup from medication cart to #187 at the table, and #187 slowly took the medications. On 6/17/14 at 9:30am, Operator/CNA (certified nurse aide) confirmed #187 and #180 received medication management by facility. The Operator failed to ensure the CMA remained with #187 and #180 until the medication administered by CMA ingested.	S5301		
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	S5315		

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S5315	Continued From page 29 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 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) The census equalled four the sample included three Residents. The facility identified all Residents with facility managed medications. Based on interviews, for three of three sampled (#189, #187, and #185) and one non sampled with facility managed medications, the Licensed nurse and Medication aides failed to ensure all medications and biologicals securely and properly stored in a locked medication cart, and only	S5315		

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S5315	Continued From page 30 licensed nurses and medication aides had access to the stored medications and biologicals. Findings included: - By interview on 6/16/14 at 1:45pm, Operator/CNA (certified nurse aide) stated some 12 hour shifts at facility staffed with a CNA and some shifts staffed with a CMA (certified medication aides). By interview on 6/16/14 at 1:45pm, Operator/CNA stated we do have TB (tuberculosis) testing solution in facility. By observation on 6/16/14 at 1:45pm, Operator/CNA obtained medication keys from CMA #A, removed the locked box from refrigerator that contained the TB solution, unlocked the box and produced the TB vial. By interview on 6/16/14 at 1:45pm, when asked who had access to medication keys, Operator/CNA stated I have a set of keys and one set stays here at facility... I thought as the Operator it was OK for me to have a set of medication keys... When asked where keys stored when CMA not on duty, Operator/CNA stated when a CMA is not coming on duty the next shift, the CMA leaving takes the keys downstairs and stores them... stated the keys although out of site, were accessible to CNA's on duty by themselves or other individuals who entered the basement (and perhaps searched for them)... The Licensed nurse and CMA's failed to ensure keys to all stored medications and biologicals accessible only to licensed nurses and medication aides.	S5315		

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