Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006004	A. BUILDING: _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	721 BEECH FORT SCOTT, KS 66701

(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 revisit for correction order 14-33 of the above home plus facility on 5/20/14 and 5/21/14.	{S 000}		
S5250 SS=D	26-42-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(10) The facility reported a census of 2 residents. The sample included 2 residents. Based on record	S5250		

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

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S5250	Continued From page 1 review and interview for 1 (#1002) of 2 residents sampled, the operator/certified medication aide (CMA) failed to ensure the resident record contained documentation of medical treatments administered. Findings included: - Record review for resident #1002 revealed an admission date of 10/1/13 and diagnoses of dementia and hypertension. The functional capacity screen dated 4/28/14 indicated the resident was unable to perform management of treatments. The negotiated service agreement dated 4/28/14 contained documentation the resident received home health services. At 5:10 p.m. on 5/20/14, the operator/CMA stated home health provided wound care to the resident. The operator/CMA provided a home health folder for the resident that contained documentation by the home health nurse dated 5/6/14 of instruction to caregiver to perform daily wound care to left lateral foot. Operator/CMA stated he/she did daily wound care to the resident's left lateral foot. Operator/CMA stated he/she cleaned the wound with wound cleanser, applied Silvadene cream to the wound bed, and covered with gauze and tape. The record lacked documentation of the daily wound care. Operator/CMA confirmed he/she did not document the daily treatment of the wound. The operator/CMA failed to ensure resident #1002's record contained documentation of medical treatments administered.	S5250		

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S5256	Continued From page 2	S5256		
S5256 SS=F	26-42-102 (b) Staff Qualifications Awake & Responsive (b) Direct care staff or licensed nursing staff shall be in attendance and responsive at all times. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(b) The facility reported a census of 2 residents. The sample included 2 residents. Based on observation, record review, and interview for 2 (#1002 and #1001) of 2 residents sampled, the operator/certified medication aide (CMA) failed to ensure direct care staff were in attendance at all times. Findings included: - Arrived at facility at 3:30 p.m. on 5/20/14 and rang doorbell, knocked on door, and called facility phone number without an answer. At 3:37 p.m. on 5/20/14, a person came out of a building directly behind the facility and introduced self as a certified nursing assistant (CNA). CNA #A stated the operator/CMA was currently away from the facility. Asked CNA #A to enter facility and meet resident #1002. CNA #A walked to the front of the facility and opened a door to a bedroom. Observed resident #1002 in bed resting on right side. Resident #1002 did not respond to verbal greeting. Walked out of resident's room and CNA #A called the operator/CMA and CNA #A then went outside. At 3:45 p.m. on 5/20/14, operator/CMA arrived at the facility and reported a census of 2 residents.	S5256		

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S5256	Continued From page 3 Operator/CNA stated resident #1001 was in the guest house watching television and that the CNA was sitting there with the resident. Operator/CMA confirmed resident #1002 was left unattended. Record review for resident #1002 revealed an admission date of 10/1/13 and diagnoses of dementia and hypertension. The functional capacity screen dated 4/28/14 indicated the resident required physical assistance with bathing, dressing, toileting, transferring, and eating; was unable to mobilize self; was unable to perform management of medications and treatments; incontinent of urine; experienced impaired short-term memory, decision making, and memory recall; was at risk for falls, and difficulty with verbal communication. Record review for resident #1001 revealed an admission date of 5/15/14 and diagnoses of dementia and hallucinations. The functional capacity screen dated 5/15/14 indicated the resident was independent with walking transferring, and eating; required physical assistance with bathing, dressing, and toileting; was unable to perform management of medications; was occasionally incontinent of urine; difficulty communicating and understanding communication; and experienced impaired short-term memory, decision making, and memory recall. For residents #1001 and #1002, the operator/ CMA failed to ensure a direct care staff member was in attendance at all times.	S5256		
{S5300} SS=F	26-42-205 (d) (1-2) Facility Administration of Medications	{S5300}		

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{S5300}	Continued From page 4 (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility reported a census of 2 residents. The sample included 2 residents. Based on record review and interview for 2 (#1001 and #1002) of 2 residents sampled, the operator/certified medication aide (CMA) failed to ensure that all medications and biologicals were administered to each resident in accordance with a medical care provider's written order and professional standards of practice. Findings included: - Record review for resident #1001 revealed an admission date of 5/15/14 and diagnoses of dementia and hallucinations. The functional capacity screen dated 5/15/14	{S5300}		

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{S5300}	Continued From page 5 indicated the resident was unable to perform medication management. The negotiated service agreement dated 5/15/14 documented the service of medication administration by CMA or registered nurse. The May 15, 2014 through May 31, 2014 medication administration record contained an entry of lorazepam [anti-anxiety medication] 0.5 milligrams (mg) one tablet every 8 hours prn [as needed]. The medication administration record contained times of 6:00 a.m., 2:00 p.m., and 8:00 p.m. as times administered with documentation by the operator/CMA that he/she administered lorazepam to the resident each day at these times from 5/15/14 through 2:00 p.m. on 5/20/14. The record lacked documentation by the registered nurse of an assessment of the resident that indicated the resident required the anti-anxiety medication. The record lacked documentation by the registered nurse of the reason a 2:00 p.m. dose and 8:00 p.m. dose was administered at a 6 hour interval and not an 8 hour interval. The record contained a medication list completed by the registered nurse on 5/15/14 and signed by the medical care provider that documented lorazepam 0.5 mg one tablet every 8 hours prn. The registered nurse wrote at the bottom of this medication list "Note-resident takes lorazepam 3 times daily for anxiety." At 4:00 p.m. on 5/20/14, the operator/CMA stated he/she routinely administered lorazepam 0.5 mg to the resident at 6:00 a.m., 2:00 p.m., and 8:00 p.m. and not on an as needed basis "because has been that way and works for [resident]---according to the doctor." The record lacked	{S5300}		

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{S5300}	Continued From page 6 documentation by a medical care provider that resident required lorazepam on a routine basis to manage anxiety. The operator/CMA failed to ensure resident #1001 received lorazepam in accordance with a medical care provider's written order and professional standards of practice. - Record review for resident #1002 revealed an admission date of 10/1/13 and diagnoses of dementia and hypertension. The functional capacity screen dated 4/28/14 indicated the resident was unable to perform medication management. The negotiated service agreement dated 4/28/14 documented the service of medication administration by CMA or registered nurse. The May 1, 2014 through May 31, 2014 medication administration record contained an entry of Xanax [anti-anxiety medication] 0.25 milligrams 1/2 to 1 tablet, 1 tablet a.m. and 1 tablet p.m. The operator/CMA documented administration of the medication two times a day 5/1/14 through a.m. dose on 5/20/14. The record contained a signed medical care provider's order for Xanax 0.25 milligrams 1/2 to 1 tablet 2 times a day. The record lacked documentation by the registered nurse of an assessment of the resident that indicated the resident required one tablet of Xanax each time and never required 1/2 tablet of Xanax. At 4:40 p.m. on 5/20/14, the operator/CMA stated he/she always administered 1 tablet of Xanax and did not administer 1/2 tablet of Xanax.	{S5300}		

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{S5300}	Continued From page 7 The operator/CMA failed to ensure resident #1002 received Xanax in accordance with a medical care provider's written order and professional standards of practice.	{S5300}		
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 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	S5315		

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S5315	Continued From page 8 expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h)(1) The facility reported a census of 2 residents. The sample included 2 residents. Based on record review, observation, and interview for 2 (#1001 and #1002) of 2 residents sampled, the operator/certified medication aide (CMA) failed to ensure controlled medications were stored in a locked compartment within a separately locked cabinet and only licensed nurses and CMAs had access to non-controlled and controlled medications. Findings included: - Arrived at facility at 3:30 p.m. on 5/20/14. At 3:37 p.m., observed an employee come from another building on the property and introduced self as a certified nursing assistant. The employee stated the operator/CMA was not at the facility at this time. At 3:45 p.m. the operator/CMA arrived at the facility. Record review for resident #1001 and #1002 revealed the facility managed medications for each resident. Each resident's negotiated service agreement documented medication administration by CMA or registered nurse. At 4:10 p.m. on 5/20/14, observed operator/CMA remove a child safety lock from a cabinet door in the room off the kitchen and remove 2 locked metal boxes from the cabinet. Operator/CMA stated each resident had a locked box for	S5315		

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S5315	Continued From page 9 medication storage. Operator/CMA then removed keys from a drawer in the cabinet that unlocked each resident box and observed each resident had bottles of controlled and non-controlled medications. Operator/CMA confirmed the child safety lock could be removed and keys to the locked box for each resident were accessible to persons not authorized to have access to medications and that controlled medications were not stored in a locked compartment within a separately locked medication cabinet. For residents #1001 and #1002, the operator/CMA failed to ensure controlled medications were stored in a locked compartment within a separately locked cabinet and only licensed nurses and CMAs had access to non-controlled and controlled medications.	S5315		
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;	S5316		

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S5316	Continued From page 10 (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 by: KAR 26-42-205(i) The facility reported a census of 2 residents. The sample included 2 residents. Based on record review, observation, and interview for 2 (#1001 and #1002) of 2 residents sampled, the operator/certified medication aide (CMA) failed to maintain records of the receipt and disposition of controlled medications managed by the facility in sufficient detail for an accurate reconciliation. Findings included: - Record review for resident #1001 revealed an admission date of 5/15/14 and diagnoses of dementia and hallucinations. The functional capacity screen dated 5/15/14 indicated the resident was unable to perform management of medications. The negotiated service agreement dated 5/15/14 documented the service of medication administration by CMA or licensed nurse. Review of the 5/15/14 through 5/31/14 medication administration record (MAR) revealed the CMA administered lorazepam [controlled medication to treat anxiety] 0.5 milligrams (mg) to the resident	S5316		

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S5316	Continued From page 11 at 6:00 a.m., 2:00 p.m., and 8:00 p.m. each day and Ambien [controlled medication for sleeplessness] each evening from the time of admission on 5/15/14. The MAR indicated that from 5/15/14 through 5/20/14, the resident received a total of 17 tablets of lorazepam and a total of 5 tablets of Ambien. The record contained a "Count sheet" that documented on 5/15/14 facility received lorazepam 0.5 mg 43 tablets and Ambien 5 mg 19 tablets. At 4:15 p.m. on 5/20/14, the operator/CMA stated he/she and nurse did not count the controlled medications to ensure an accurate reconciliation. Observed operator/ CMA count the tablets remaining for the 2 controlled medications and 25 tablets of lorazepam remained and 13 tablets of Ambien remained. Operator/CMA confirmed that there should have been 26 tablets of lorazepam remaining and 14 tablets of Ambien remaining. Operator/CMA could not account for the missing 1 tablet of Ambien and 1 tablet of Lorazepam. The operator/CMA failed to maintain records of the receipt and disposition of controlled medications managed by the facility for resident #1001 in sufficient detail for an accurate reconciliation. - Record review for resident #1002 revealed an admission date of 10/1/13 and diagnoses of dementia and hypertension. The functional capacity screen dated 4/28/14 indicated the resident was unable to perform medication management. The negotiated service agreement dated 4/28/14 documented the service of medication administration by CMA or licensed nurse. Review of the 5/1/14 through 5/31/14 medication	S5316		

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S5316	Continued From page 12 administration record contained documentation that resident received the controlled medications of Xanax [anti-anxiety medication] 0.25 milligrams (mg) 1/2 to 1 tablet two times a day and Ambien [for sleeplessness] 5 mg 1 tablet at bedtime. At 4:55 p.m. on 5/20/14, the operator/CMA stated he/she documented number of tablets received at the facility when prescription refilled but did not sign out for the controlled medications or count number of tablets remaining routinely with the licensed nurse. The operator/CMA failed to maintain records of the receipt and disposition of controlled medications managed by the facility for resident #1002 in sufficient detail for an accurate reconciliation.	S5316		
{S5325} SS=F	26-42-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist or licensed nurse shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the home and each time the resident experiences any significant change in condition. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(l) The facility reported a census of 2 residents. The sample included 2 residents. Based on record	{S5325}		

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{S5325}	Continued From page 13 review and interview for 1 (#1002) of 2 residents sampled, the operator/certified medication aide (CMA) failed to ensure a licensed nurse or licensed pharmacist conducted a medication regimen review at least quarterly for each resident whose medication was managed by the facility and each time the resident experienced any significant change in condition. Findings included: - Record review for resident #1002 revealed an admission date of 10/1/13 and diagnoses of dementia and hypertension. The significant change functional capacity screen dated 4/28/14 indicated the resident was unable to perform medication management. The negotiated service agreement dated 4/28/14 documented the service of medication administration by CMA or registered nurse. The record lacked a medication regimen review by a licensed nurse or licensed pharmacist at least quarterly from the time of the resident's admission to the facility on 10/1/13 and when the resident experienced a significant change in condition. At 5:00 p.m. on 5/20/14, the operator/CMA stated there was not a system in place to ensure residents received medication regimen reviews. The operator/CMA failed to ensure a licensed nurse or licensed pharmacist conducted a medication regimen review at least quarterly for each resident whose medication was managed by the facility and each time the resident experienced any significant change in condition.	{S5325}		

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{S5326} SS=F	26-42-205 (l) (1) Medication Regimen Review Contents (l) (1) The medication regimen review shall identify any potential or current medication-related problems, including the following: (A) Lack of clinical indication for use of medication; (B) the use of a subtherapeutic dose of any medication; (C) failure of the resident to receive an ordered medication; (D) medications administered in excessive dosage, including duplicate therapy; (E) medications administered in excessive duration; (F) adverse medication reactions; (G) medication interactions; and (H) lack of adequate monitoring. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(l)(1)(A)(B)(C)(D)(E)(F)(G)(H) The facility reported a census of 2 residents. The sample included 2 residents. Based on record review and interview for 1 (#1002) of 2 residents sampled, the operator/certified medication aide (CMA) failed to ensure a licensed nurse or licensed pharmacist conducted a quarterly medication regimen review that identified any potential or current medication-related problems that included lack of clinical indication for use of medication; the use of a sub therapeutic dose of any medication; failure of the resident to receive an ordered medication; medications administered in excessive dosage, including duplicate therapy; medications administered in excessive duration;	{S5326}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006004	A. BUILDING: _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{S5326}	Continued From page 15 adverse medication reactions; medication interactions; and lack of adequate monitoring. Findings included: - Record review for resident #1002 revealed an admission date of 10/1/13 and diagnoses of dementia and hypertension. The significant change functional capacity screen dated 4/28/14 indicated the resident was unable to perform medication management. The negotiated service agreement dated 4/28/14 documented the service of medication administration by CMA or registered nurse. The record lacked medication regimen reviews by a licensed nurse or licensed pharmacist at least quarterly from the time of the resident's admission to the facility on 10/1/13 and when the resident experienced a significant change in condition. At 5:00 p.m. on 5/20/14, the operator/CMA stated there was not a system in place to ensure residents received medication regimen reviews. Operator/CMA confirmed a licensed nurse or licensed pharmacist did not monitor medications each resident received for potential or current medication-related problems. For resident #1002, the operator/CMA failed to ensure a licensed nurse or licensed pharmacist conducted a quarterly medication regimen review that identified any potential or current medication-related problems that included lack of clinical indication for use of medication; the use of a sub therapeutic dose of any medication; failure of the resident to receive an ordered medication;	{S5326}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{S5326}	Continued From page 16 medications administered in excessive dosage, including duplicate therapy; medications administered in excessive duration; adverse medication reactions; medication interactions; and lack of adequate monitoring.	{S5326}		