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 _____	04/29/2014

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 resurvey conducted at the above named facility on 4-28-14 and 4-29-14.	S 000		
S5300 SS=F	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility identified a census of 1Resident. The sampled included 1 Resident. Based on record review and interview for 1 (#100) of 1 Resident sampled, the Operator and Licensed Nurse failed to ensure all medications are administered to Resident in accordance with a medical care provider's written order, professional standards of practice and each manufacturer's recommendations.	S5300		

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

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S5300	Continued From page 1 Findings included: - Record review for Resident #100 revealed an admit date of 10-1-13 with diagnoses of Dementia. The Functional Capacity Screen dated 10-1-13 recorded Resident unable to manage medications. The Negotiated Service Agreement dated 10-1-13 recorded the facility staff managed medications. The record contained a form that recorded (facility name) and "Drug Regimen." The Drug Regimen form contained the following medications dated 10-1-13: Furosemide 20 Milligrams (MG) daily Metoprolol 25 MG one tablet two times a day Amlodipine 10 MG one tablet daily Lisinopril 20 MG one tabled two times a day Clopidogrel 75 MG one tablet daily Isosorbide 30 MG 1/2 tablet daily Tylenol PM extra strength 2 tablets at 8:00 p.m. daily Xanax .25 MG 1/2 tablet two times a day at 1:00 a.m. and 1:00 p.m. Zolpidem 5 MG one table at 8:00 p.m. daily Metamucil 2 table tablespoons (TBS) daily as needed Flaxseed Oil one TBS two or three times a day Tobramycin two times daily one drop daily each eye Latanoprost 0.005% one drop each eye at 8:00 p.m. daily Haloperidol 0.5 MG one two times a day at 8:00 a.m. and 8:00 p.m. This document lacked signed physician orders for	S5300		

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S5300	Continued From page 2	S5300		

all medications to be administered from 10-1-13 through 10-18-13. On 10-18-14 orders received to administer medications.

Interview on 4-28-14 at 2:50 p.m. with Operator/CMA stated, " Used the Drug Regimen form as the written physician orders."

The Medication Administration Record (MAR) dated 10-1-13 through 10-28-13 lacked documentation that Haloperidol 0.5 MG one tablet two times a day was administered. The MAR recorded Haloperidol 0.5 MG to 1 MG administered 10-28-13 through 10-31-13 two times a day. The MAR lacked documentation to identify what dose was administered.

The record contained a written physician order (drug regimen) dated 11-3-13 that recorded Haloperidol .5 MG in a.m. and increase to 1 MG two times a day.

The MAR dated 11-3-13 recorded Haloperidol 0.5 MG increase to 1 MG one two times a day. The initials recorded Haloperidol 1 MG administered at 8:00 a.m. and 8:00 p.m.

The MAR dated 12-1-13 through 12-31-13 recorded Haloperidol .5 MG two tablets two times a day may have one or two in p.m. The MAR contained initials that Resident received Haloperidol 1 MG two tablets two times a day.

The signed Drug Regimen order dated 1-3-14 recorded Haloperidol .5 MG one two times a day.

The MAR dated 1-1-14 through 1-31-14 recorded Haloperidol one .5 MG tablet in a.m. and one or two tablets in p.m. The MAR lacked documentation of actual dose administered to

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S5300	Continued From page 3 Resident. The MAR dated 2-2-14 through 2-28-14 recorded Haloperidol .5 MG one in a.m. and one or two tablets in p.m. The MAR lacked documentation of actual dose administered to p.m. The signed Drug Regimen order dated 3-2-14 recorded Haloperidol .5 MG one tablet in a.m. and one or two tablets in p.m. The MAR dated 3-2-14 through 3-31-14 recorded Haloperidol .5 MG one tablet in a.m. and two tablets in p.m. The MAR lacked documentation of actual dose administered in p.m. The signed Drug Regimen order dated 4-2-14 recorded Haloperidol .5 MG in a.m. and 1 or 2 tablets in p.m. The MAR dated 4-2-14 through 4-28-14 recorded Haloperidol .5 MG one tablet in a.m. and 1 to 2 tablets in p.m. The MAR lacked documentation of actual dose administered in p.m. Interview on 4-28-14 at 3:07 p.m. with Operator/CMA stated, "(He/She) administered Haloperidol .5 MG two tablets at 8:00 p.m. every night." The Operator/CMA confirmed the order recorded Haloperidol .5 MG one or two tablets in p.m. and the MAR lacked actual dose administered to Resident in p.m. The Operator/CMA stated the Licensed Nurse came to facility weekly to review Resident's record and failed to identify the p.m. dose of Haloperidol to be administered. For Resident #100, the Operator and Licensed Nurse failed to ensure all medications are administered to Resident in accordance with a	S5300		

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S5300	Continued From page 4 medical care provider's written order, professional standards of practice and each manufacturer's recommendations.	S5300		
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 identified a census of 1 Resident. The sample included 1 Resident. Based on record review and interview of 1 (#100) of 1 Resident sampled, the Operator failed to ensure a licensed pharmacist or licensed nurse conducted a drug regimen review at least quarterly for Resident #100. Findings included: - Record review for Resident #100 revealed an admit date of 10-1-13 with diagnoses of Dementia. The Functional Capacity Screen dated 10-1-13 recorded Resident unable to manage medications.	S5325		

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S5325	Continued From page 5 The Negotiated Service Agreement dated 10-1-13 recorded the facility staff managed medications. The record contained a form that recorded (facility name) and "Drug Regimen." The Drug Regimen form contained the following medications dated 10-1-13: Furosemide 20 Milligrams (MG) daily Metoprolol 25 MG one tablet two times a day Amlodipine 10 MG one tablet daily Lisinopril 20 MG one tabled two times a day Clopidogrel 75 MG one tablet daily Isosorbide 30 MG 1/2 tablet daily Tylenol PM extra strength 2 tablets at 8:00 p.m. daily Xanax .25 MG 1/2 tablet two times a day at 1:00 a.m. and 1:00 p.m. Zolpidem 5 MG one table at 8:00 p.m. daily Metamucil 2 table tablespoons (TBS) daily as needed Flaxseed Oil one TBS two or three times a day Tobramycin two times daily one drop daily each eye Latanoprost 0.005% one drop each eye at 8:00 p.m. daily Haloperidol 0.5 MG one two times a day at 8:00 a.m. and 8:00 p.m. Interview on 4-28-14 at 2:55 p.m. with Operator/Certified Medication Aide (CMA) stated, "(He/She) writes name of medications on the Drug Regimen form and sends to the physician to sign and make any changes." The record lacked a quarterly medication regimen review by a licensed pharmacist or licensed nurse.	S5325		

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S5325	Continued From page 6 For Resident #100, the Operator/CMA failed to ensure a licensed pharmacist or licensed nurse conducted a drug regimen review at least quarterly for Resident #100.	S5325		
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 identified a census of 1 Resident. The sample included 1 Resident. Based on record review and interview for 1 (#100) of 1 Resident sampled, the Operator failed to ensure the drug regimen review identified any potential or current medication-related problems including the following: Lack of clinical indication for use of medication;	S5326		

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S5326	Continued From page 7	S5326		

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; adverse medication reactions; medication interactions; and lack of adequate monitoring.

Findings included:

- Record review for Resident #100 revealed an admit date of 10-1-13 with diagnoses of Dementia.

The Functional Capacity Screen dated 10-1-13 recorded Resident unable to manage medications.

The Negotiated Service Agreement dated 10-1-13 recorded the facility staff managed medications.

The record contained a form that recorded (facility name) and "Drug Regimen." The Drug Regimen form contained the following medications dated 1-3-14:
Furosemide 20 Milligrams (MG) daily
Metoprolol 25 MG one tablet two times a day
Amlodipine 10 MG one tablet daily
Lisinopril 20 MG one tabled two times a day
Clopidogrel 75 MG one tablet daily
Isosorbide 30 MG 1/2 tablet daily
Tylenol PM extra strength 2 tablets at 8:00 p.m. daily
Xanax .25 MG 1/2 tablet two times a day at 1:00 a.m. and 1:00 p.m.
Zolpidem 5 MG one table at 8:00 p.m. daily
Metamucil 2 table tablespoons (TBS) daily as needed
Flaxseed Oil one TBS two or three times a day

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S5326	Continued From page 8 Tobramycin two times daily one drop daily each eye Latanoprost 0.005% one drop each eye at 8:00 p.m. daily Haloperidol 0.5 MG one two times a day at 8:00 a.m. and 8:00 p.m. Interview on 4-28-14 at 2:55 p.m. with Operator/Certified Medication Aide (CMA) stated, "(He/She) writes name of medications on the Drug Regimen form and sends to the physician to sign and make any changes." For Resident #100, the Operator failed to ensure the drug regimen review identified any potential or current medication-related problems including the following: 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; adverse medication reactions; medication interactions; and lack of adequate monitoring.	S5326		