STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006003	A. BUILDING: _____ B. WING _____	03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE GUEST HOME	1115 227TH ST 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 initail survey at the above named facility on 3-17-14, 3-18-14, 3-19-14, 3-20-14, 3-24-14, 3-25-14, and 3-26-14.	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)(2)(c) The facility identified a census of 7 Residents. The sample included 3 Residents. Based on record review and interview for 3 (#100, #111, #222) of 3 Residents sampled, the Operator failed to ensure at time of admission each	S 230		

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

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S 230	Continued From page 1 Resident received in writing state statutes related to advance medical directive, develop and implementation of policies and procedures related to advance medical directives, and adult care home's grievance policy to each Resident prior to signing admission agreement. Findings included: - Record reviews for Residents #100, #111, and #222 lacked information in writing that statutes relate to advance medical directives and information on facility's grievance policy provided to each Resident. Interview on 3-17-14 at 3:00 p.m. with Operator stated and confirmed each Resident was not informed in writing about advance directives or home's grievance policy. For Residents #100, #111, #222, the Operator failed to ensure at time of admission each Resident received in writing state statutes related to advance medical directive, develop and implementation of policies and procedures related to advance medical directives, and adult care home's grievance policy to each Resident prior to signing admission agreement.	S 230		
S5005 SS=F	26-42-101(b) Administrator/Operater Criteria (b) Administrator and operator criteria. Each licensee shall appoint an administrator or operator who meets the following criteria: (1) Is at least 21 years of age; (2) possesses a high school diploma or the equivalent; (3) holds a Kansas license as an adult care home administrator or has successfully completed an	S5005		

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S5005	Continued From page 2 operator training course and passed the test approved by the secretary of Kansas department of health and environment pursuant to K.S.A. 39-923 and amendments thereto; and (4) has authority and responsibility for the operation of the home and compliance with licensing requirements. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(b)(4) The facility identifed a census of 7 Residents. The sample included 3 Residents. Based on record review, interview, and observation for 3 (#100, #111, #222) of 3 Residents sampled, the licensee/Operator/Certified Medication Aide (CMA) failed to ensure the facility's compliance with licensing requirements as evidenced by: -Failure to ensure a licensed nurse assessed residents whose functional capacity screening indicated the need for health care services. -Failure to ensure the resident's negotiated service agreement contained the name of the licensed nurse responsible for the supervision of the plan. -Failure to ensure a licensed nurse planned, coordinated, and supervised necessary health care services specific to each resident. -Failure to ensure a licensed nurse received orders from a medical care provider and implemented the orders. - Failure to ensure medications were administered in accordance with a written medical care provider's order. - Failure to ensure medications were stored in a locked cabinet. -Failure to maintain resident records according to standards of practice.	S5005		

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S5005	Continued From page 3	S5005		

- Failure to provide a quarterly review of the facility's emergency management plan and failed to conduct an emergency drill at least annually with evacuation of the resident to a secure location.

Findings included:

- On 3-18-14 at 1:00 p.m., Operator/CMA stated had a Licensed Nurse that was his/her friend. The Licensed Nurse used to be around the facility all the time until December 2013 when had a disagreemt on "some things" and he/she quit coming to facility unless Opearator/CMA call Licensed Nurse to come to facility. Operator/CMA stated he/she called the Licensed Nurse #A to admit Resident #100 on 3-6-14. The Operator/CMA stated Licensed Nurse #A had not been to facility since December 2013 until 3-6-14.

- Record review for Resident #100 revealed an admit date of 3-6-14 with diagnoses of Seizures and Cerebral Vascular Accident with Left Sided Paralysis.

The Functional Capacity Screen (FCS) dated 3-6-14 recorded Resident #100 required supervision with walking/mobility, eating, physical assistance with bathing, dressing, management of medications and treatments. The FCS lacked documentation for toileting and transfer. The FCS was signed by Licensed Nurse #A and lacked date signed.

The Negotiated Service Agreement (NSA)/HCS dated 3-6-14 recorded Resident #100 to receive regular diet with small portions due to gastric bypass. Staff will assist with bathing two times a week, toileting if needed, transfer as needed, supervision for ambulation with cane, medications

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S5005	Continued From page 4 per Medication Administration Record (MAR) and facility will manage medications. The NSA/HCS plan was signed by Licensed Nurse #A and dated 3-14-14. The NSA/HCS lacked the name of the Licensed Nurse responsible for implementation and supervision of HCS. The record lacked documentation of an assessment of resident #100 at admission and nurses notes or documentation following admission. The record lacked written physician orders when admitted to facility on 3-6-14. The Licensed Nurse failed to obtain written physician orders for medications when Resident admitted to facility. The Resident record lacked a current MAR since admitted to the facility on 3-6-14 and interview at 10:35 a.m. on 3-17-14 with Operator/CMA " confirmed no current MAR at this time." The record contained physician orders dated 3-10-14 for following medications: Zocor (Simvastin) 40 MG one every night for hyperlipidemia Naproxen 220 MG once daily for pain Zofran (ondansetron) 4 MG every 8 hours as needed for nausea/vomiting Zyrtec 10 MG one tablet every am for allergies Mirtazapine (Remeron) 30 MG at bedtime for depression Levetiraceta (KEPPRA) 1000 MG two times daily for seizures Klonopin (Clonazepam).5 MG two times daily in afternoon and bedtime for anxiety Meloxicam (Mobic) 7.5 MG every day for arthritis pain	S5005		

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S5005	Continued From page 5 Cymbalta 300 MG one every day for depression Micro K 20 MEQ on tablet daily Prilosec (Omeprazole) 20 MG one every day (for reflux) Vitamin E 1000 Units twice daily Telephone interview on 3-24-14 at 12:00 p.m. with Operator/CMA stated, "(Resident #100) did not have any medications available on 3-6-14 when admitted to facility and confirmed Resident did not receive medications until 3-10-14 when went to physician's office." Telephone interview on 3-24-14 at 1:32 p.m. with Licensed Nurse #A stated, "(Resident #100) came to facility on 3-6-14 and he/she completed the FCS/NSA. The Resident did not have any medications with him/her. Further stated the Operator/CMA was taking care of getting medications for the weekend and did not follow up with Resident getting medications." Interview at 9:45 a.m. on 3-17-14 with Resident #100 stated, required physical assistance with bathing, dressing, independent with toileting, transfer, walking with cane, eating, wears glasses, has anxiety daily and when goes out to stores. Resident stated, takes Xanax for anxiety and prior to going out in public places and the facility ordered and administered his/her medications. Resident stated Operator/CMA administered the medications. The record lacked an order for Xanax. Observation of medication box lacked Xanax. - Record review for Resident #111 revealed an	S5005		

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S5005	Continued From page 6	S5005		

admit date of 12-1-13 with diagnoses of Dementia, Hypertension, Heart Disease and Atrial Fibrillation.

The FCS dated 12-1-13 recorded Resident required supervision with eating, bladder incontinence, decision making, communication, required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, management of medications/treatments and experienced falls/unsteadiness.

The NSA/HCP dated 12-1-13 recorded supervision for eating, incontinent care, impaired decision making, physical assistance with bathing, dressing, toileting, transfer, propels self in wheelchair staff assist when needed, facility managed medications and treatments. The NSA/HCP lacked documentation of care to be provided for bladder incontinence, decision making, falls/unsteadiness and name of Licensed Nurse responsible for implementation and supervision of HCS.

The MAR dated 3-1-14 recorded Resident received the following medications:
Aspirin 81 MG every day at 8:00 a.m.
Fish Oil 500 MG every day at 8:00 a.m.
Naproxin (Naproxen) 500 MG every day at 8:00 a.m.
Pardaxia 75 MG two times a day at 8:00 a.m. and 5:00 p.m.
Bisoprolol/HCTZ 25 MG/6.25 MG two times day at 8:00 a.m. and 5:00 p.m.
Citalopram 20 MG every day at 5:00 p.m. (for depression)
Pravastation 20 MG every day at 5:00 p.m. (for hyperlipidemia)
Tramadol 50 MG as needed for pain
Alprazolam .25 MG as needed for anxiety

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S5005	Continued From page 7 The record lacked physician orders for medication, nurses notes or other documentation of assessments or incidents. Interview on 3-18-14 at 11:40 a.m. with Resident #111 stated loved the food and the Operator administered the medications he/she took. Observed Resident propel self to dining room area. Interview on 3-18-14 at 12:00 p.m. with Operator/CMA stated and confirmed the record lacked written physician orders, documentation of any notes, communication notes, and further stated he/she completed the MAR and recorded all medication orders on the MAR. - Record review for Resident #222 revealed an admit date of 11-16-13 with diagnoses of Kidney Disorder and Atrial Fibrillation. The FCS dated 11-16-13 recorded the Resident required supervision for toileting, eating, bladder incontinence, physical assistance with bathing, dressing, transfer, walking/mobility, management of medications/treatments, experienced short term memory loss, decision making, and falls/unsteadiness. The NSA/HCS dated 11-16-13 recorded Resident #222 had a regular diet, required physical assistance with bathing, toileting, wears hearing aide due to hard of hearing, physical assistance with transferring as needed, uses roller seated walker, and staff will administer medications as ordered by the physician. Resident has had falls recently and has a lifeline call bracelet. The NSA/HCS lacked the name of the Licensed	S5005		

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S5005	Continued From page 8 Nurse responsible for implementation and supervision of HCS. The MAR dated 3-1-14 recorded the following medications were administered: Furosemide 40 MG two times a day give second dose at 1:00 p.m. Note: The MAR initialed by Operator/CMA recorded Furosemide 40 MG administered at 8:00 a.m. every day. No record of second dose administered. Lisinopril 10 MG one table daily at 8:00 a.m. (hypertension) Klor-Con 10 MEQ one tablet with each Furosemide given. MAR initial administered at 8:00 a.m. every day Vitamin D3 1000 units one every day at 8:00 a.m. Loratadine 10 MG one tablet every day at 8:00 a.m. (antihistamine) Cartia 240 MG one every day at 8:00 a.m. (for hypertension) Iron Fe 65 MG one tablet daily at 8:00 a.m. Gabapentin 100 MG three times a day at 8:00 a.m., 1:00 p.m., 5:00 p.m. Metoprolol 25 MG tow times a day at 8:00 a.m. and 5:00 p.m. Citalopram 10 MG one every day at 5:00 p.m. for depression Simvastatin 20 MG one table every day at 5:00 p.m. Baclofen 10 MG three times a day as needed for muscle spasms Hydrocodone 5/325 MG .5 to 1 tablet for pain as needed The record lacked physician orders for medication, nurses notes or other documentation of assessments or incidents.	S5005		

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S5005	Continued From page 9 Interview on 3-18-14 at 12:00 p.m. with Operator/CMA stated and confirmed the record lacked written physician orders, documentation of any notes, communication notes, further stated he/she completed the MAR and recorded all medication orders on the MAR. Operator/CMA confirmed Furosemide was not administered as MAR identified and should have given second dose of Furosemide by 1:00 p.m every day. The Operator/ CMA further stated, "he/she had been doing the MAR's since 1-1-14 and Certified Staff #C helped him/her." Interview on 3-18-14 at 12:25 p.m. with Operator/CMA stated Resident had rectal bleeding and was sent to hospital on 1-6-14 and returned back to facility on 1-14-14. Operator/CMA stated and confirmed this was not recorded in communication or nurses notes. For resident #222, the Operator/CMA failed to ensure health care services provided by qualified staff in accordance with standards of practice when the operator failed to ensure a licensed nurse implemented physician orders and provided supervision to certified staff providing care to Resident #222. The operator further failed to ensure the licensed nurse documented an assessment of #222 and documented indication of illness and follow up when resident #222 developed symptoms that required hospitalization for rectal bleeding. Interview on 3-17-14 at 1:40 p.m. with Operator/CMA stated had not conducted a quarterly review of the emergency management plan with staff or Residents. On 3-17-14 at 2:45 p.m. observed medication boxes unsecured in maintenance room and	S5005		

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S5005	Continued From page 10 Operator/CMA confirmed medication boxes not secured. The resident records lacked documentation of care the resident received and any incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. The record lacked any documentation by a facility licensed nurse. For Residents #100, #111, and #222, the Operator/CMA failed to ensure the facility's compliance with licensing requirements to employ a licensed nurse to assess resident's health care needs in order to plan, implement, coordinate, and supervise health care services provided by certified staff; to provide direction to certified staff for residents unscheduled health care needs; and to communicate with the medical care provider regarding resident's health care needs and to accept, note, and implement the medical care provider's orders. The licensee/Operator/CMA further failed to ensure the facility's compliance with licensing requirements to maintain a resident record according to standards of practice, conduct emergency management education and drills.	S5005		
S5050 SS=F	26-42-101 (k) Ombudsman (k) Ombudsman. Each administrator or operator shall ensure the posting of the names, addresses, and telephone numbers of the Kansas department on aging and the office of the long-term care ombudsman with information that these agencies can be contacted to report actual or potential abuse, neglect, or exploitation of residents or to register complaints concerning the	S5050		

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S5050	Continued From page 11	S5050		

operation of the home. The administrator or operator shall ensure that this information is posted in a common area accessible to all residents and the public.

This REQUIREMENT is not met as evidenced by:
KAR 26-42-101(k)

The facility identified a census of 7 Residents. The sample included 3 Residents. Based on record review, interview, and observations for all Residents, the operator failed to post names, addresses, and telephone numbers for Kansas Department on Aging, and the office of the long-term Ombudsman with information that these agencies can be contacted to report actual or potential abuse, neglect, or exploitation of Residents. The Operator failed to ensure all this information is posted in a common area accessible to all Residents and the public.

Findings included:

- Tour of facility on 3-17-14 at 1:30 p.m. revealed no phone numbers for the Department, long-term Ombudsman, addresses or phone number with information to report actual or potential abuse, neglect, or exploitation of Residents.

Interview on 3-17-14 at 1:35 p.m. with the Operator stated did not have anything posted for the numbers of the Department, Ombudsman, or number to report abuse, neglect, and exploitation.

For all Residents, the operator failed to post names, addresses, and telephone numbers for Kansas Department on Aging, and the office of the long-term Ombudsman with information that

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S5050	Continued From page 12 these agencies can be contacted to report actual or potential abuse, neglect, or exploitation of Residents. The Operator failed to ensure all this information is posted in a common area accessible to all Residents and the public.	S5050		
S5161 SS=F	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 identified a census of 7 Residents. The sample included 3 Residents. Based on record review and interview for 3 (#100, #111, #222) of 3 Residents sampled, the Operator/Certified Medication Aide (CMA) failed to ensure the Negotiated Service Agreement (NSA) identified the name of the Licensed Nurse responsible for the implementation and supervision of the Health Care Service Plan (HCSP). Findings included: - Record review for Resident #100 revealed an admit date of 3-6-14 with diagnoses of Seizures and Cerebral Vascular Accident with Left Sided Paralysis. The Functional Capacity Screen (FCS) dated 3-6-14 recorded Resident #100 required	S5161		

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S5161	Continued From page 13	S5161		

supervision with walking/mobility, eating, physical assistance with bathing, dressing, management of medications and treatments. The FCS lacked documentation for toileting and transfer.

The Negotiated Service Agreement (NSA)/Health Care Services (HCS) dated 3-6-14 recorded Resident #100 to receive regular diet with small portions due to gastric bypass. Staff will assist with bathing two times a week, toileting if needed, transfer as needed, supervision for ambulation with cane, medications per Medication Administration Record (MAR) and facility will manage medications. The NSA/HCS plan was signed by Licensed Nurse #A and dated 3-14-14. The NSA/HCS lacked the name of the Licensed Nurse responsible for implementation and supervision of HCS.

Interview at 9:45 a.m. on 3-17-14 with Resident #100 stated, required physical assistance with bathing, dressing, independent with toileting, transfer, walking with cane, eating, wears glasses, has anxiety daily and when goes out to stores. Resident stated, takes Xanax for anxiety and prior to going out in public places and the facility ordered and administered his/her medications. Resident stated Operator/CMA administered the medications. The record lacked an order for Xanax. Observation of medication box lacked Xanax.

Interview at 1:00 p.m. on 3-18-14 with Operator/CMA stated, Licensed Nurse #A is a good friend and he/she used to come to the facility all the time until they had a disagreement on " some things " and then Licensed Nurse #A quit coming around and started working at another facility. The Operator/CMA confirmed the

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	B006003	A. BUILDING: _____ B. WING _____	03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE GUEST HOME	1115 227TH ST 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
S5161	Continued From page 14 HCSP lacked the name or signature of the Licensed Nurse responsible for implementation and supervision of the HCS. - Record review for Resident #111 revealed an admit date of 12-1-13 with diagnoses of Dementia, Hypertension, Heart Disease and Atrial Fibrillation. The FCS dated 12-1-13 recorded Resident required supervision with eating, bladder incontinence, decision making, communication, required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, management of medications/treatments and experienced falls/unsteadiness. The NSA/HCP dated 12-1-13 recorded supervision for eating, incontinent care, impaired decision making, physical assistance with bathing, dressing, toileting, transfer, propels self in wheelchair staff assist when needed, facility managed medications and treatments. The NSA/HCP lacked documentation of care to be provided for bladder incontinence, decision making, and falls/unsteadiness. Interview on 3-18-14 at 11:40 a.m. with Resident #111 stated loved the food and the Operator administered the medications he/she took. Observed Resident propel self to dining room area. Interview on 3-18-14 at 12:00 p.m. with Operator/CMA stated and confirmed the record lacked written physician orders, documentation of any notes, communication notes, and further stated he/she completed the MAR and recorded all medication orders on the MAR. The Operator/CMA also confirmed the HCS lacked	S5161		

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S5161	Continued From page 15 the name of the Licensed Nurse responsible for implementation and supervision of HCS. - Record review for Resident #222 revealed an admit date of 11-16-13 with diagnoses of Kidney Disorder and Atrial Fibrillation. The FCS dated 11-16-13 recorded the Resident required supervision for toileting, eating, bladder incontinence, physical assistance with bathing, dressing, transfer, walking/mobility, management of medications/treatments, experienced short term memory loss, decision making, and falls/unsteadiness. The NSA/HCS dated 11-16-13 recorded Resident #222 had a regular diet, required physical assistance with bathing, toileting, wears hearing aide due to hard of hearing, physical assistance with transferring as needed, uses roller seated walker, and staff will administer medications as ordered by the physician. Resident has had falls recently and has a lifeline call bracelet. Interview on 3-18-14 at 12:25 p.m. with Operator/CMA stated Resident had rectal bleeding and was sent to hospital on 1-6-14 and returned back to facility on 1-14-14. Operator/CMA stated and confirmed this was not recorded in communication or nurses notes. The Operator/CMA stated and confirmed the HCS lacked the name of the Licensed Nurse responsible for implementation and supervision of HCS. For Residents #100, #111, and #222, the Operator/CMA failed to ensure the NSA identified the name of the Licensed Nurse responsible for the implementation and supervision of the HCSP.	S5161		

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S5171	Continued From page 16	S5171		
S5171 SS=F	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 facility identified a census of 7 Residents. The sample included 3 Residents and 2 closed records reviewed. Based on record review, interview, and observations for 3 (#100, #111, #222) of 3 Residents sampled, the Operator failed to ensure all Health Care Services (HCS) were provided to these Residents by qualified staff in accordance with acceptable standards of practice. Findings included: - Record review for Resident #100 revealed an admit date of 3-6-14 with diagnoses of Seizures and Cerebral Vascular Accident with Left Sided Paralysis. The Functional Capacity Screen (FCS) dated 3-6-14 recorded Resident #100 required supervision with walking/mobility, eating, physical assistance with bathing, dressing, management of medications and treatments. The FCS lacked documentation for toileting and transfer. The FCS was signed by Licensed Nurse #A and lacked date signed. The Negotiated Service Agreement (NSA)/HCS dated 3-6-14 recorded Resident #100 to receive	S5171		

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S5171	Continued From page 17	S5171		

regular diet with small portions due to gastric bypass. Staff will assist with bathing two times a week, toileting if needed, transfer as needed, supervision for ambulation with cane, medications per Medication Administration Record (MAR) and facility will manage medications. The NSA/HCS plan was signed by Licensed Nurse #A and dated 3-14-14.

The record lacked documentation of an assessment of resident #100 at admission and nurses notes or documentation following admission.

The record lacked written physician orders when admitted to facility on 3-6-14.

The record contained a MAR from the previous facility dated 3-1-14 which recorded resident #100 received the following medications from 3-1-14 through 3-6-14:

Aspirin 81 Milligrams (MG) (for blood thinner)
Zyrtec 10 MG every 12 hours for allergies
Cymbalta 60 MG take two capsules by mouth daily (for depression)
Meloxicam 7.5 MG one tablet every day for arthritis
Remeron 30 MG one tablet at bedtime for depression
Omega 3 1000 MG capsules take two every day for lipids
Prilosec (Omeprazole) 20 MG one capsule by mouth every day (for reflux)
Micro K 20 Milliequivalents (MEQ) on tablet daily
Zocor (Simvastin) 40 MG one tablet every night (for hyperlipidemia)
Ambien 5 MG every night for insomnia
Tylenol 325 MG two tablets twice daily for pain
Klonopin (Clonazepam) 0.5 MG one tablet two

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S5171	Continued From page 18	S5171		

times a day in afternoon and bedtime for anxiety
Levetiraceta (KEPPRA) 1000 MG twice daily for seizures
Vitamin D 1000 Units twice daily
Mucinex 600 MG Extended Release one tablet every 12 hours as needed for congestion
Zofran (ondansetron) 4 MG take one tablet every 8 hours as needed for nausea
Flonase nasal spray use two times a day each nostril for nasal congestion
Melatonin 3 MG every night at bedtime for insomnia

The Resident record lacked a current MAR since admitted to the facility on 3-6-14 and interview at 10:35 a.m. on 3-17-14 with Operator/CMA " confirmed no current MAR at this time."

The record contained physician orders dated 3-10-14 for following medications:

Zocor (Simvastin) 40 MG one every night for hyperlipidemia
Naproxen 220 MG once daily for pain
Zofran (ondansetron) 4 MG every 8 hours as needed for nausea/vomiting
Zyrtec 10 MG one tablet every am for allergies
Mirtazapine (Remeron) 30 MG at bedtime for depression
Levetiraceta (KEPPRA) 1000 MG two times daily for seizures
Klonopin (Clonazepam).5 MG two times daily in afternoon and bedtime for anxiety
Meloxicam (Mobic) 7.5 MG every day for arthritis pain
Cymbalta 300 MG one every day for depression
Micro K 20 MEQ on tablet daily
Prilosec (Omeprazole) 20 MG one every day (for reflux)
Vitamin E 1000 Units twice daily

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S5171	Continued From page 19 Telephone interview on 3-24-14 at 12:00 p.m. with Operator/CMA stated, "(Resident #100) did not have any medications available on 3-6-14 when admitted to facility and confirmed Resident did not receive medications until 3-10-14 when went to physician's office." Telephone interview on 3-24-14 at 1:32 p.m. with Licensed Nurse #A stated, "(Resident #100) came to facility on 3-6-14 and he/she completed the FCS/NSA. The Resident did not have any medications with him/her. Further stated the Operator/CMA was taking care of getting medications for the weekend and did not follow up with Resident getting medications." Review of Food and Drug Administration and Drug Safety information for Remeron, Cymbalta, Klonopin, and Levetiraceta (KEPPRA) recorded Do Not Stop Abruptly. Information documented stopping these medication abruptly could cause seizures that would not stop, tremors, vertigo, confusion, weakness, mood swings, headache, sleep changes, brief feeling similar to electrical shock, and suicidal thoughts. Interview at 9:45 a.m. on 3-17-14 with Resident #100 stated, required physical assistance with bathing, dressing, independent with toileting, transfer, walking with cane, eating, wears glasses, has anxiety daily and when goes out to stores. Resident stated, takes Xanax for anxiety and prior to going out in public places and the facility ordered and administered his/her medications. Resident stated Operator/CMA administered the medications. The record lacked an order for Xanax. Observation of medication box lacked Xanax.	S5171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S5171	Continued From page 20 Interview at 1:00 p.m. on 3-18-14 with Operator/CMA stated, Licensed Nurse #A is a good friend and he/she used to come to the facility all the time until they had a disagreement on " some things " and then Licensed Nurse #A quit coming around and started working at another facility. Operator/CMA stated Licensed Nurse #A would come to the facility if he/she called and did not call him/her until had new admit on 3-6-14. For resident #100, the operator failed to ensure health care services provided by qualified staff in accordance with standards of practice when resident #100 was admitted without current medication orders; the licensed nurse failed to document an assessment and notify the physician or obtain physician orders for medications that were unsafe to staff abruptly. The operator further failed to ensure a licensed nurse implemented physician orders and provided supervision to certified staff providing care to Resident #100 including development and maintenance of a medication administration record. Resident #100 was not provided medication for 4 days, including medications to treat/prevent seizures, depression and anxiety. - Record review for Resident #111 revealed an admit date of 12-1-13 with diagnoses of Dementia, Hypertension, Heart Disease and Atrial Fibrillation. The FCS dated 12-1-13 recorded Resident required supervision with eating, bladder incontinence, decision making, communication, required physical assistance with bathing, dressing, toileting, transfer, walking/mobility,	S5171		

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S5171	Continued From page 21	S5171		

management of medications/treatments and experienced falls/unsteadiness.

The NSA/HCP dated 12-1-13 recorded supervision for eating, incontinent care, impaired decision making, physical assistance with bathing, dressing, toileting, transfer, propels self in wheelchair staff assist when needed, facility managed medications and treatments. The NSA/HCP lacked documentation of care to be provided for bladder incontinence, decision making, and falls/unsteadiness.

The MAR dated 3-1-14 recorded Resident received the following medications:
Aspirin 81 MG every day at 8:00 a.m.
Fish Oil 500 MG every day at 8:00 a.m.
Naproxin (Naproxen) 500 MG every day at 8:00 a.m.
Pardaxia 75 MG two times a day at 8:00 a.m. and 5:00 p.m.
Bisoprolol/HCTZ 25 MG/6.25 MG two times day at 8:00 a.m. and 5:00 p.m.
Citalopram 20 MG every day at 5:00 p.m. (for depression)
Pravastation 20 MG every day at 5:00 p.m. (for hyperlipidemia)
Tramadol 50 MG as needed for pain
Alprazolam .25 MG as needed for anxiety

The record lacked physician orders for medication, nurses notes or other documentation of assessments or incidents.

Interview on 3-18-14 at 11:40 a.m. with Resident #111 stated loved the food and the Operator administered the medications he/she took. Observed Resident propel self to dining room area.

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S5171	Continued From page 22 Interview on 3-18-14 at 12:00 p.m. with Operator/CMA stated and confirmed the record lacked written physician orders, documentation of any notes, communication notes, and further stated he/she completed the MAR and recorded all medication orders on the MAR. For resident #111, the operator failed to ensure health care services provided by qualified staff in accordance with standards of practice when resident #111 the licensed nurse failed to document an assessment and implement physician orders for medications. . The operator further failed to ensure a licensed nurse provided supervision to certified staff providing care to Resident #111. - Record review for Resident #222 revealed an admit date of 11-16-13 with diagnoses of Kidney Disorder and Atrial Fibrillation. The FCS dated 11-16-13 recorded the Resident required supervision for toileting, eating, bladder incontinence, physical assistance with bathing, dressing, transfer, walking/mobility, management of medications/treatments, experienced short term memory loss, decision making, and falls/unsteadiness. The NSA/HCS dated 11-16-13 recorded Resident #222 had a regular diet, required physical assistance with bathing, toileting, wears hearing aide due to hard of hearing, physical assistance with transferring as needed, uses roller seated walker, and staff will administer medications as ordered by the physician. Resident has had falls recently and has a lifeline call bracelet.	S5171		

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S5171	Continued From page 23 The MAR dated 3-1-14 recorded the following medications were administered: Furosemide 40 MG two times a day give second dose at 1:00 p.m. Note: The MAR initialed by Operator/CMA recorded Furosemide 40 MG administered at 8:00 a.m. every day. No record of second dose administered. Lisinopril 10 MG one table daily at 8:00 a.m. (hypertension) Klor-Con 10 MEQ one tablet with each Furosemide given. MAR initial administered at 8:00 a.m. every day Vitamin D3 1000 units one every day at 8:00 a.m. Loratadine 10 MG one tablet every day at 8:00 a.m. (antihistamine) Cartia 240 MG one every day at 8:00 a.m. (for hypertension) Iron Fe 65 MG one tablet daily at 8:00 a.m. Gabapentin 100 MG three times a day at 8:00 a.m., 1:00 p.m., 5:00 p.m. Metoprolol 25 MG tow times a day at 8:00 a.m. and 5:00 p.m. Citalopram 10 MG one every day at 5:00 p.m. for depression Simvastatin 20 MG one table every day at 5:00 p.m. Baclofen 10 MG three times a day as needed for muscle spasms Hydrocodone 5/325 MG .5 to 1 tablet for pain as needed The record lacked physician orders for medication, nurses notes or other documentation of assessments or incidents. Interview on 3-18-14 at 12:00 p.m. with Operator/CMA stated and confirmed the record lacked written physician orders, documentation of	S5171		

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S5171	Continued From page 24 any notes, communication notes, further stated he/she completed the MAR and recorded all medication orders on the MAR. Operator/CMA confirmed Furosemide was not administered as MAR identified and should have given second dose of Furosemide by 1:00 p.m every day. The Operator/ CMA further stated, "he/she had been doing the MAR's since 1-1-14 and Certified Staff #C helped him/her." Interview on 3-18-14 at 12:25 p.m. with Operator/CMA stated Resident had rectal bleeding and was sent to hospital on 1-6-14 and returned back to facility on 1-14-14. Operator/CMA stated and confirmed this was not recorded in communication or nurses notes. For resident #222, the operator failed to ensure health care services provided by qualified staff in accordance with standards of practice when the operator failed to ensure a licensed nurse implemented physician orders and provided supervision to certified staff providing care to Resident #222. The operator further failed to ensure the licensed nurse documented an assessment of #222 and documented indication of illness and follow up when resident #222 developed symptoms that required hospitalization for rectal bleeding. For Residents #100, #111, and #222, the Operator failed to ensure all HCS were provided to these Residents by qualified staff in accordance with acceptable standards of practice.	S5171		
S5190 SS=F	26-42-206 (d) Dietary Services (d)(1) Menu plans shall be available to each	S5190		

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S5190	Continued From page 25 resident on at least a weekly basis. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(d((1) The facility identified a census of 7 Residents. The sampled included 3 Residents. Based on record review, interview, and observation for all Residents, the Operator failed to ensure menu plans available to each Resident on at least a weekly basis. Findings included: - On 3-17-14 at 1:50 p.m. tour of kitchen and dining area lacked documentation of a weekly menu plan available to the Residents. On 3-17-14 at approximately 1:52 p.m., the Operator stated and confirmed a weekly menu was not posted and just had a daily menu written on dry eraser board. For all Residents, the Operator failed to ensure menu plans available to each Resident on at least a weekly basis.	S5190		
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	S5215		

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S5215	Continued From page 26 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 identifide a census of 7 Residents. The sample included 3 residents. Based on record review and interview for all Residents, the Operator/Certified Medication Aide (CMA) failed to provide a quarterly review of the facility's emergency management plan with the Residents or employees. Findings included: - On 3-17-14 at 1:40 p.m., the Operator/CMA stated, "Had not performed a quarterly review of the emergencvy management plan with Residents or employees." For all Residents and employees, the Operator/CMA failed to provide a quarterly review of the facility's emergency management plan.	S5215		
S5251 SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents	S5251		

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S5251	Continued From page 27 (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-420105(f)(11) The facility identified a census of 7 Residents. The sample included 3 Residents. Based on record review and interview for 2 (#111, #222) of 3 Residents sample, the Operator/Certified Medication Aide (CMA) failed to ensure documentation of all incident, signs/symptoms, and other indications of illness or injury included the date, time of occurrence, action taken, and results of action taken. Findings included: - Record review for Resident #100 revealed an admit date of 3-6-14 with diagnoses of Seizures and Cerebral Vascular Accident with Left Sided Paralysis. The Functional Capacity Screen (FCS) dated 3-6-14 recorded Resident #100 required supervision with walking/mobility, eating, physical assistance with bathing, dressing, management of medications and treatments. The FCS lacked documentation for toileting and transfer. The FCS was signed by Licensed Nurse #A and lacked date signed. The Negotiated Service Agreement (NSA)/HCS	S5251		

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	B006003	A. BUILDING: _____ B. WING _____	03/26/2014

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HILLSIDE GUEST HOME	1115 227TH ST FORT SCOTT, KS 66701

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S5251	Continued From page 28 dated 3-6-14 recorded Resident #100 to receive regular diet with small portions due to gastric bypass. Staff will assist with bathing two times a week, toileting if needed, transfer as needed, supervision for ambulation with cane, medications per Medication Administration Record (MAR) and facility will manage medications. The NSA/HCS plan was signed by Licensed Nurse #A and dated 3-14-14. The record lacked documentation of an assessment of resident #100 at admission and nurses notes or documentation following admission. The record lacked written physician orders when admitted to facility on 3-6-14. The Resident record lacked a current MAR since admitted to the facility on 3-6-14 and interview at 10:35 a.m. on 3-17-14 with Operator/CMA " confirmed no current MAR at this time." The record contained physician orders dated 3-10-14 for following medications: Zocor (Simvastin) 40 MG one every night for hyperlipidemia Naproxen 220 MG once daily for pain Zofran (ondansetron) 4 MG every 8 hours as needed for nausea/vomiting Zyrtec 10 MG one tablet every am for allergies Mirtazapine (Remeron) 30 MG at bedtime for depression Levetiraceta (KEPPRA) 1000 MG two times daily for seizures Klonopin (Clonazepam).5 MG two times daily in afternoon and bedtime for anxiety Meloxicam (Mobic) 7.5 MG every day for arthritis pain	S5251		

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Cymbalta 300 MG one every day for depression
Micro K 20 MEQ on tablet daily
Prilosec (Omeprazole) 20 MG one every day (for reflux)
Vitamin E 1000 Units twice daily

Telephone interview on 3-24-14 at 12:00 p.m. with Operator/CMA stated, "(Resident #100) did not have any medications available on 3-6-14 when admitted to facility and confirmed Resident did not receive medications until 3-10-14 when went to physician's office."

Telephone interview on 3-24-14 at 1:32 p.m. with Licensed Nurse #A stated, "(Resident #100) came to facility on 3-6-14 and he/she completed the FCS/NSA. The Resident did not have any medications with him/her. Further stated the Operator/CMA was taking care of getting medications for the weekend and did not follow up with Resident getting medications."

The record lacked documentation of time physician was notified Resident did not have medications available, any signs/symptom of illness from lack of medications not available, the date, time of occurrence, actions taken, and results of actions taken.

- Record review for Resident #222 revealed and admit date of 11-16-13 with diagnoses of Kidney Disorder and Atrial Fibrillation.

The FCS dated 11-16-13 recorded the Resident required supervision for toileting, eating, bladder incontinence, physical assistance with bathing, dressing, transfer, walking/mobility, management of medications/treatments, experienced short term memory loss, decision making, and

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S5251	Continued From page 30 falls/unsteadiness. The NSA/HCS dated 11-16-13 recorded Resident #222 had a regular diet, required physical assistance with bathing, toileting, wears hearing aide due to hard of hearing, physical assistance with transferring as needed, uses roller seated walker, and staff will administer medications as ordered by the physician. Resident has had falls recently and has a lifeline call bracelet. The record lacked documentation of any communication notes, nurses notes, illness, injury, date, time of occurrence, action taken, and results of actions taken. Interview on 3-18-14 at 12:25 p.m. with Operator/CMA stated Resident had rectal bleeding and was sent to hospital on 1-6-14 and returned back to facility on 1-14-14. Operator/CMA stated and confirmed this was not recorded in communication or nurses notes. For Resident #222, the Operator/CMA failed to ensure documentation of all incidents, signs/symptoms, and other indications of illness or injury included the date, time of occurrence, action taken, and results of action taken.	S5251		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training;	S5258		

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S5258	Continued From page 31 (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(d)(2) The facility identified a census of 7 Residents. The sample included 3 Residents. Based on 4 (#B, #C, #D, #H) of 4 Certified Staff record reviews, the Operator/Certified Medication Aide (CMA) failed to ensure records contained supporting documentation for criminal background checks for Certified Staff pursuant to K.S.A. 39-970. Findings included: - On 3-18-14 at 1:40 p.m., reviewed personnel with Operator/CMA. The personnel record identified Certified Staff #B hired in 1999, Certified Staff #C hired on 10-22-13, Certified Staff #D hired on 9-9-13, and Certified Staff #H hired on 1-1-14, lacked criminal background checks per K.S.A. 39-970.	S5258		

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S5258	Continued From page 32 Interview on 3-18-14 at approximately 1:41 p.m. with Operator/CMA stated did not know criminal background checks had to be done per the Department. For Certified Staff #B, #C, #D, and #H, the Operator/CMA failed to ensure records contained supporting documentation for criminal background checks for Certified Staff pursuant to K.S.A. 39-970.	S5258		
S5315 SS=D	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	S5315		

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S5315	Continued From page 33 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 facility identified a census of 7 Residents. The sample included 3 Residents. Based on record review, observation and interview for 1 (#222) of 3 Residents sampled, the Licensed Nurse and Certified Medication Aide (CMA) failed to ensure all medications are securely and properly stored in accordance with manufacturer's recommendations. Findings included: - Record review for Resident #222 revealed an admit date of 11-16-13 with diagnoses of Kidney Disorder and Atrial Fibrillation. The FCS dated 11-16-13 recorded the Resident required physical assistance with management of medications/treatments. The NSA/HCS dated 11-16-13 recorded Resident #222 recorded facility staff will administer medications as ordered by the physician. On 3-17-14 at 2:35 p.m., observed a prescription bottle labeled with Resident #222's name, in the medication refrigerator. The bottle contained 58	S5315		

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S5315	Continued From page 34 1/2 tablets of hydrocodone. The Medication Administration Record (MAR) dated 3-1-14 recorded the Resident had hydrocodone 5/325 MG .5 to 1 tablet for pain as needed. Interview on 3-17-14 at approximately 2:35 p.m. with Operator/CMA stated, "kept the hydrocodone in the refrigerator." The temperature in refrigerator on 3-17-14 at 2:35 p.m. was 38 degrees. The food and drug administration for storage of lortab stated, "Lortab should be stored between 68 degrees and 77 degrees in a dry air tight light sensitive container. For Resident #222, the Licensed Nurse and CMA failed to ensure all medications are securely and properly stored in accordance with manufacturer's recommendations.	S5315		
S5320 SS=F	26-42-205 (k) Medication Clinical Records (k) Clinical record. The administrator or operator, or the designee, shall ensure that the clinical record of each resident for whom the home manages the resident ' s medication or prefills medication containers or syringes contains the following documentation: (1) A medical care provider ' s order for each medication; (2) the name of the pharmacy provider of the resident ' s choice; (3) any known medication allergies; and (4) the date and the 12-hour or 24-hour clock time any medication is administered to the	S5320		

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S5320	Continued From page 35 resident. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(k) The facility identified a census of 7 Residents. The sample included 3 Residents. Based on record review and interview for 3 (#100, #111, #222) of 3 Residents sampled, the Operator/Certified Medication Aide (CMA) failed to ensure the clinical record of each Resident contained a medical care provider's order for each medication. For Resident #100, the Operator/CMA failed to record date and time of each medication administered. Findings included: - Record review for Resident #100 revealed an admit date of 3-6-14 with diagnoses of Seizures and Cerebral Vascular Accident with Left Sided Paralysis. The Functional Capacity Screen (FCS) dated 3-6-14 recorded Resident #100 required physical assistance with management of medications and treatments. The Negotiated Service Agreement (NSA)/HCS dated 3-6-14 recorded the facility staff will manage and administer medications. The record lacked written physician orders when admitted to facility on 3-6-14. On 3-10-14	S5320		

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S5320	Continued From page 36 Resident went to physician to get orders for medications. The record contained a Medication Administration Record from the previous facility dated 3-1-14 which recorded resident #100 received the following medications from 3-1-14 through 3-6-14: Aspirin 81 Milligrams (MG) (for blood thinner) Zyrtec 10 MG every 12 hours for allergies Cymbalta 60 MG take two capsules by mouth daily (for depression) Meloxicam 7.5 MG one tablet every day for arthritis Remeron 30 MG one tablet at bedtime for depression Omega 3 1000 MG capsules take two every day for lipids Prilosec (Omeprazole) 20 MG one capsule by mouth every day (for reflux) Micro K 20 Milliequivalents (MEQ) on tablet daily Zocor (Simvastin) 40 MG one tablet every night (for hyperlipidemia) Ambien 5 MG every night for insomnia Tylenol 325 MG two tablets twice daily for pain Klonopin (Clonazepam) 0.5 MG one tablet two times a day in afternoon and bedtime for anxiety Levetiraceta (KEPPRA) 1000 MG twice daily for seizures Vitamin D 1000 Units twice daily Mucinex 600 MG Extended Release one tablet every 12 hours as needed for congestion Zofran (ondansetron) 4 MG take one tablet every 8 hours as needed for nausea Flonase nasal spray use two times a day each nostril for nasal congestion Melatonin 3 MG every night at bedtime for insomnia	S5320		

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The Resident record lacked a current MAR since admitted to the facility on 3-6-14 and interview at 10:35 a.m. on 3-17-14 with Operator/CMA " confirmed no current MAR at this time."

The record contained physician orders dated 3-10-14 for following medications:

Zocor (Simvastin) 40 MG one every night for hyperlipidemia
Naproxen 220 MG once daily for pain
Zofran (ondansetron) 4 MG every 8 hours as needed for nausea/vomiting
Zyrtec 10 MG one tablet every am for allergies
Mirtazapine (Remeron) 30 MG at bedtime for depression
Levetiraceta (KEPPRA) 1000 MG two times daily for seizures
Klonopin (Clonazepam).5 MG two times daily in afternoon and bedtime for anxiety
Meloxicam (Mobic) 7.5 MG every day for arthritis pain
Cymbalta 300 MG one every day for depression
Micro K 20 MEQ on tablet daily
Prilosec (Omeprazole) 20 MG one every day (for reflux)
Vitamin E 1000 Units twice daily

Telephone interview on 3-24-14 at 12:00 p.m. with Operator/CMA stated, "(Resident #100) did not have any medications available on 3-6-14 when admitted to facility and confirmed Resident did not receive medications until 3-10-14 when went to physician's office."

Telephone interview on 3-24-14 at 1:32 p.m. with Licensed Nurse #A stated, "(Resident #100) came to facility on 3-6-14 and he/she completed the FCS/NSA. The Resident did not have any medications with him/her. Further stated the

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S5320	Continued From page 38 Operator/CMA was taking care of getting medications for the weekend and did not follow up with Resident getting medications." Interview at 9:45 a.m. on 3-17-14 with Resident #100 stated, the facility ordered and administered his/her medications. Resident stated Operator/CMA administered the medications. For resident #100, the Operator/CMA failed to ensure that clinical record contained medical care provider's order for each medication and failed to record the date, time and any medication administered to the Resident. - Record review for Resident #111 revealed an admit date of 12-1-13 with diagnoses of Dementia, Hypertension, Heart Disease and Atrial Fibrillation. The FCS dated 12-1-13 recorded Resident required physical assistance with management of medications/treatments. The NSA/HCP dated 12-1-13 recorded facility will manage and administer medications. The MAR dated 3-1-14 recorded Resident received the following medications: Aspirin 81 MG every day at 8:00 a.m. Fish Oil 500 MG every day at 8:00 a.m. Naproxin (Naproxen) 500 MG every day at 8:00 a.m. Pardaxia 75 MG two times a day at 8:00 a.m. and 5:00 p.m. Bisoprolol/HCTZ 25 MG/6.25 MG two times day at 8:00 a.m. and 5:00 p.m. Citalopram 20 MG every day at 5:00 p.m. (for	S5320		

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depression)
Pravastation 20 MG every day at 5:00 p.m. (for hyperlipidemia)
Tramadol 50 MG as needed for pain
Alprazolam .25 MG as needed for anxiety

The record lacked physician orders for medications.

Interview on 3-18-14 at 11:40 a.m. with Resident #111 stated the Operator administered the medications he/she took.

Interview on 3-18-14 at 12:00 p.m. with Operator/CMA stated and confirmed the record lacked written physician orders.

For resident #111, the Operator/CMA failed to ensure that clinical record contained medical care provider's order for each medication

- Record review for Resident #222 revealed an admit date of 11-16-13 with diagnoses of Kidney Disorder and Atrial Fibrillation.

The FCS dated 11-16-13 recorded the Resident required physical assistance with management of medications/treatments.

The NSA/HCS dated 11-16-13 recorded the facility staff will administer medications as ordered by the physician.

The MAR dated 3-1-14 recorded the following medications were administered:
Furosemide 40 MG two times a day give second dose at 1:00 p.m. Note: The MAR initialed by Operator/CMA recorded Furosemide 40 MG

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administered at 8:00 a.m. every day. No record of second dose administered.
Lisinopril 10 MG one table daily at 8:00 a.m. (hypertension)
Klor-Con 10 MEQ one tablet with each Furosemide given. MAR initial administered at 8:00 a.m. every day
Vitamin D3 1000 units one every day at 8:00 a.m.
Loratadine 10 MG one tablet every day at 8:00 a.m. (antihistamine)
Cartia 240 MG one every day at 8:00 a.m. (for hypertension)
Iron Fe 65 MG one tablet daily at 8:00 a.m.
Gabapentin 100 MG three times a day at 8:00 a.m., 1:00 p.m., and 5:00 p.m.
Metoprolol 25 MG tow times a day at 8:00 a.m. and 5:00 p.m.
Citalopram 10 MG one every day at 5:00 p.m. for depression
Simvastatin 20 MG one table every day at 5:00 p.m.
Baclofen 10 MG three times a day as needed for muscle spasms
Hydrocodone 5/325 MG .5 to 1 tablet for pain as needed

The record lacked physician orders for medications.

Interview on 3-18-14 at 12:00 p.m. with Operator/CMA stated and confirmed the record lacked written physician orders.

For Residents #100, #111, and #222, the Operator/CMA failed to ensure the clinical record of each Resident contained a medical care provider's written order for each medication. For Resident #100, the Operator/CMA failed to record date and time of each medication administered.

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HILLSIDE GUEST HOME	1115 227TH ST 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
S5325	Continued From page 41	S5325		
S5325 SS=E	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 7 Residents. The sample included 3 Residents. Based on record review and interview for 2 (#111, #222) of 3 Residents sampled, the operator failed to ensure a pharmacist or licensed nurse conducted a medication regimen review at least quarterly for each Resident whose medications is managed by the facility. Findings included: - Record review for Resident #111 revealed an admit date of 12-1-13 with diagnoses of Dementia, Hypertension, Heart Disease and Atrial Fibrillation. The FCS dated 12-1-13 recorded Resident required physical assistance with management of medications and treatments. The NSA/HCP dated 12-1-13 recorded facility	S5325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006003	A. BUILDING: _____ B. WING _____	03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE GUEST HOME	1115 227TH ST 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
S5325	Continued From page 42	S5325		

managed medications and treatments.

The MAR dated 3-1-14 recorded Resident received the following medications:
Aspirin 81 MG every day at 8:00 a.m.
Fish Oil 500 MG every day at 8:00 a.m.
Naproxin (Naproxen) 500 MG every day at 8:00 a.m.
Pardaxia 75 MG two times a day at 8:00 a.m. and 5:00 p.m.
Bisoprolol/HCTZ 25 MG/6.25 MG two times day at 8:00 a.m. and 5:00 p.m.
Citalopram 20 MG every day at 5:00 p.m. (for depression)
Pravastation 20 MG every day at 5:00 p.m. (for hyperlipidemia)
Tramadol 50 MG as needed for pain
Alprazolam .25 MG as needed for anxiety

The record lacked a quarterly drug regimen review.

Interview on 3-18-14 at 11:40 a.m. with Resident #111 stated the Operator administered the medications.

Interview on 3-18-14 at 12:00 p.m. with Operator/CMA stated and confirmed the record lacked a quarterly drug regimen review.

- Record review for Resident #222 revealed an admit date of 11-16-13 with diagnoses of Kidney Disorder and Atrial Fibrillation.

The FCS dated 11-16-13 recorded the Resident required physical assistance with management of medications and treatments.

The NSA/HCS dated 11-16-13 recorded facility

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	B006003	A. BUILDING: _____ B. WING _____	03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5325	Continued From page 43 staff will administer medications as ordered by the physician. The MAR dated 3-1-14 recorded the following medications were administered: Furosemide 40 MG two times a day give second dose at 1:00 p.m. Note: The MAR initialed by Operator/CMA recorded Furosemide 40 MG administered at 8:00 a.m. every day. No record of second dose administered. Lisinopril 10 MG one table daily at 8:00 a.m. (hypertension) Klor-Con 10 MEQ one tablet with each Furosemide given. MAR initial administered at 8:00 a.m. every day Vitamin D3 1000 units one every day at 8:00 a.m. Loratadine 10 MG one tablet every day at 8:00 a.m. (antihistamine) Cartia 240 MG one every day at 8:00 a.m. (for hypertension) Iron Fe 65 MG one tablet daily at 8:00 a.m. Gabapentin 100 MG three times a day at 8:00 a.m., 1:00 p.m., and 5:00 p.m. Metoprolol 25 MG tow times a day at 8:00 a.m. and 5:00 p.m. Citalopram 10 MG one every day at 5:00 p.m. for depression Simvastatin 20 MG one table every day at 5:00 p.m. Baclofen 10 MG three times a day as needed for muscle spasms Hydrocodone 5/325 MG .5 to 1 tablet for pain as needed The record lacked a quarterly drug regimen review. Interview on 3-18-14 at 12:00 p.m. with Operator/CMA stated and confirmed the record	S5325		

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S5325	Continued From page 44 lacked written physician orders or a quarterly drug regimen review. For Residents #111 and #222, the operator failed to ensure a pharmacist or licensed nurse conducted a medication regimen review at least quarterly for each Resident whose medications is managed by the facility. .	S5325		
S5326 SS=E	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	S5326		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006003	A. BUILDING: _____ B. WING _____	03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE GUEST HOME	1115 227TH ST FORT SCOTT, KS 66701

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S5326	Continued From page 45 by: KAR 26-42-205(l)(1)(A)(B)(C)(D)(E)(F)(G)(H) The facility identified a census of 7 Residents. The sample included 3 Residents. Based on record review and interview for 2 (#111 and #222) of 3 Residents sampled, the Operator/Certified Medication Aide (CMA) failed to ensure a licensed nurse or licensed pharmacist conducted a quarterly medication regimen review to identify 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; adverse medication reactions; medication interactions; and lack of adequate monitoring. Findings included: - Record review for resident #111 revealed an admission date of 12-1-13. The Functional Capacity Screen dated 12-1-13 indicated the Resident required physical assistance with management of medications and treatments. The Negotiated Service Agreement dated 12-1-13 contained the service of management of medications; and management of treatments. The MAR dated 3-1-14 recorded Resident received the following medications: Aspirin 81 MG every day at 8:00 a.m. Fish Oil 500 MG every day at 8:00 a.m. Naproxin (Naproxen) 500 MG every day at 8:00	S5326		

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	B006003	A. BUILDING: _____ B. WING _____	03/26/2014

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S5326	Continued From page 46 a.m. Pardaxia 75 MG two times a day at 8:00 a.m. and 5:00 p.m. Bisoprolol/HCTZ 25 MG/6.25 MG two times day at 8:00 a.m. and 5:00 p.m. Citalopram 20 MG every day at 5:00 p.m. (for depression) Pravastation 20 MG every day at 5:00 p.m. (for hyperlipidemia) Tramadol 50 MG as needed for pain Alprazolam .25 MG as needed for anxiety The record lacked documentation of a quarterly medication regimen review by a licensed nurse or licensed pharmacist. The record lacked documentation of any potential or current medication related problems. Interview on 3-18-14 at 12:00 p.m. with Operator/CMA stated and confirmed the record lacked a quarterly drug regimen review. - Record review for Resident #222 revealed an admit date of 11-16-13 with diagnoses of Kidney Disorder and Atrial Fibrillation. The FCS dated 11-16-13 recorded the Resident required physical assistance with management of medications and treatments. The NSA/HCS dated 11-16-13 recorded facility staff will administer medications as ordered by the physician. The MAR dated 3-1-14 recorded the following medications were administered: Furosemide 40 MG two times a day give second dose at 1:00 p.m. Note: The MAR initialed by Operator/CMA recorded Furosemide 40 MG	S5326		

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S5326	Continued From page 47	S5326		

administered at 8:00 a.m. every day. No record of second dose administered.
Lisinopril 10 MG one table daily at 8:00 a.m. (hypertension)
Klor-Con 10 MEQ one tablet with each Furosemide given. MAR initial administered at 8:00 a.m. every day
Vitamin D3 1000 units one every day at 8:00 a.m.
Loratadine 10 MG one tablet every day at 8:00 a.m. (antihistamine)
Cartia 240 MG one every day at 8:00 a.m. (for hypertension)
Iron Fe 65 MG one tablet daily at 8:00 a.m.
Gabapentin 100 MG three times a day at 8:00 a.m., 1:00 p.m., and 5:00 p.m.
Metoprolol 25 MG tow times a day at 8:00 a.m. and 5:00 p.m.
Citalopram 10 MG one every day at 5:00 p.m. for depression
Simvastatin 20 MG one table every day at 5:00 p.m.
Baclofen 10 MG three times a day as needed for muscle spasms
Hydrocodone 5/325 MG .5 to 1 tablet for pain as needed

The record lacked a quarterly drug regimen review or potential or current medication related problems.

Interview on 3-18-14 at 12:00 p.m. with Operator/CMA stated and confirmed the record lacked written physician orders or a quarterly drug regimen review.

For Residents #111 and #222, the Operator/CMA failed to ensure a licensed nurse or licensed pharmacist conducted a quarterly medication regimen review to identify any potential or current

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S5326	Continued From page 48 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; adverse medication reactions; medication interactions; and lack of adequate monitoring.	S5326		