STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENN MOORE MEADOWS	214TH ROAD HOLTON, KS 66436

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S 000	INITIAL COMMENTS The following deficiencies are the result of a Licensure Resurvey at the above named Home Plus Facility in Holton, Kansas on 3/17/14 and 3/18/14. Revised 2567 sent to facility 3/19/14.	S 000		
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 expiration.	S5315		

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

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S5315	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h) The census equalled eight the sample included three Residents. The facility identified seven with facility managed medications. Based on observation and interview, for three of three sampled (#189, #187, and #185), and four non-sampled Residents, the Licensed Nurses and Medication Aides failed to ensure that all medications and biologicals securely stored and accessible only to those authorized to administer the medications. Findings included: - On 3/17/14 at 12:38pm, a female Resident sat in a roller walker with seat, in the West entrance of kitchen, next to North kitchen cabinets. At this time, Certified Nurse Aide #C moved in and out of the kitchen and dining and living room areas, completing light housekeeping tasks and noon meal clean up. By observation #C removed keys from the North Kitchen counter drawer left of kitchen sink, and entered a locked storage room with stored canned goods, cleaning supplies, and a small refrigerator labeled for medications. The refrigerator contained a small black metal lock box, but was otherwise empty. Operator/Owner/Certified Medication Aide #A stated the black metal lock box contained one unopened vial of tuberculosis testing solution. At 12:39pm Operator/Owner/Certified Medication Aide #A opened drawer of North kitchen counter, left of kitchen sink, and removed a ring of keys.	S5315		

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S5315	Continued From page 2 #A then unlocked the lower cabinets to the right of kitchen sink with one of the keys. These cabinets contained plastic bins of Resident medications and treatment items. These cabinets contained the locked metal box designated for controlled medications. The keys allowed entrance and access to all medications and biologicals in the kitchen cabinets, and in the storage room and lock box inside the designated medication refrigerator. On 3/17/14 at 12:39pm, Operator/Owner/Certified Medication Aide #A confirmed the keys used to unlock the storage room with the medication refrigerator and lock box, and the key to unlock the medication and treatment cabinets routinely stored in the drawer left of the kitchen sink... #A stated we have always kept the keys in that drawer, stated when I have to go outside to the barn or to the mail box, did not want to take the chance of losing the keys... #A confirmed the North kitchen drawer accessible to any individual in the facility, including residents, family , visitors, and staff not authorized to administer medications. Licensed Nurses and Medication Aides failed to ensure that medications and biologicals for all Residents with facility managed medications, were securely stored and accessible only to those authorized to administer the medications.	S5315		
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:	S5326		

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S5326	Continued From page 3 (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) The census equalled eight the sample included three Residents. The facility identified seven with facility managed medications. Based on review of record and interview, for two of three sampled (#185 and #187), the Operator failed to ensure the medication regimen review identified any potential medication-related problem, to include medications on the MAR (medication administration record) in the absence of a current signed medical care provider order, and the absence of physician ordered medications on the MAR. Findings included: - Record review revealed #185 admitted to facility 10/01/18 with diagnoses of Dementia, Post menopause, Depression, Hypertension, and Stress incontinence. The current functional capacity screen of 6/01/13 assessed #185 unable to perform (3) medication and treatment	S5326		

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S5326	Continued From page 4	S5326		

management. The current 5/24/13 negotiated service agreement documented facility staff to administer medications and treatments.

Comparison of the current March 2014 MAR and current signed physician orders revealed discrepancies:

POS's (physician order sheets) of 3/03/14; 02/03/14; 12/12/13; each contained an order for Pepto Bismol to be used PRN (as needed). The March 2014 MAR lacked this medication. The medical record lacked an order to discontinue the Pepto Bismol. The POS's observed to contain duplicate orders for Biofreeze analgesic topical to areas of pain PRN.

The medical record contained medication regimen reviews, completed by the Facility Nurse #B on 02/28/14; 01/31/14; 12/31/13; and 11/30/13. The medication regimen reviews failed to identify this discrepancy between current signed orders and the current MAR.

On 3/17/14 at 3:39pm, the Operator/Owner/Certified Medication Aide #A confirmed the MAR's lacked the medication Pepto Bismol included in the recent POS's... acknowledged the monthly medication regimen reviews failed to identify the discrepancy.

The Operator failed to ensure the medication regimen review for #185 identified any potential medication-related problem, to include the absence of physician ordered medications on the MAR.

- Record review revealed #187 admitted to

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facility 01/01/14 with diagnoses of Hypertension, Atrial fibrillation, Hypercholesterolemia, Compression fracture, Congestive heart failure, Osteoporitis, Gout, Diverticulitis, Depression, Insomnia, and Hematoma of soft tissue. The current functional capacity screen of 01/01/14 assessed #187 unable to perform (3) medication and treatment management. The current 01/01/14 negotiated service agreement documented facility staff to administer medications and treatments.

Comparison of the current March 2014 MAR (medication administration record) and current signed physician orders revealed a discrepancy:

The March 2014 MAR contained an order for Imodium 4mg (milligrams) po (by mouth) after 3rd loose stool, then 2mg after loose stool for diarrhea, not to exceed 16mg daily PRN (as needed).
By review, this order not included on the POS (physician order sheet) of 3/04/14 or 02/03/14. An original order located in the medical record dated 01/24/14.

On 3/17/14 at 2:30pm, Operator/Owner/Certified Medication Aide #A confirmed the absence of this order on recent POS's... stated not sure #187 ever took the medication

On 3/17/14 at 2:45pm Facility Nurse #B acknowledged the absence of a current order for the medication ... #B contacted the physician's office for clarification.

The medical record contained medication regimen reviews, completed by the Facility Nurse #B on 02/28/14 and 01/31/14. The medication regimen reviews failed to identify this discrepancy

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S5326	Continued From page 6 between current signed orders and the current MAR. The Operator failed to ensure the medication regimen review for #187 identified any potential medication-related problem, to include the presence of medications on the MAR in the absence of a current signed medical care provider's order.	S5326		