STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B073001	A. BUILDING: _____ B. WING _____	03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LARNED HOME PLUS	710 W 9TH STREET LARNED, KS 67550

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named home plus facility on 3-5-14 and 3-6-15.	S 000		
S5251 SS=D	26-42-105 (f) (11) Resident Records Documentation of Incidents (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 26-42-105 (f)(11) The census equalled eight the sample included three Residents. Based on reviews of records and interview, for one of three sampled (#185), the Operator failed to ensure the medical record contained documentation of all accidents, incidents, symptoms, date, time, actions taken and response to the actions. Findings included: -Review of record revealed #185 admitted to facility 12/12/13 with diagnoses of Chronic anxiety, Reactional depression, Constipation, Hypertension, Dementia, and High fall risk. The current 12/12/13 functional capacity screen assessed #185 unable to perform (3) medication and treatment management, and in need of physical assistance (2) with bathing, dressing, toileting, transfers, mobility, eating; with cognitive impairment; and with falls and unsteadiness. The current 12/12/13 negotiated service agreement documented facility staff to administer medications and to provide physical assistance with all cares. The medical record " Resident	S5251		

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

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S5251	Continued From page 1 Progress Notes " contained a 12/20/13 entry: #185 fell ... stated he/she hurt or was a little sore on left side just below rib cage ... also stated may have bumped head ... o apparent damage done ... talked with family and decided to monitor him/her closely for any further symptoms ... fax sent to physician ... The next entry in the medical record of 12/20/13 noted vital signs, and a new order received for lab. On 12/23/13 the following entry documented #185 went to the doctor today ...has a fractured rib and start of pneumonia ... new order received and processed ... The medical record lacked any documentation of " monitoring " or follow-up from the time of the fall on 12/20/13 at 0700, until the note on 12/23/13 at 1300. On 3/05/14 at 3:45pm, the Residence Nurse confirmed no documentation in the medical record related to monitoring or follow up to #185 ' s fall and complaints of pain in rib area. On 3/05/14 at 4:05pm, Registered Nurse #A stated the follow-up/monitoring of #185 consisted of staff being in and out of his/her room frequently and checking on him/her ... #A confirmed no further assessment or monitoring documented. The Operator failed to ensure the medical record for #185 contained documentation of actions taken and the results of the actions taken, related to accidents and injuries.	S5251		
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	S5300		

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S5300	Continued From page 2 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 census equalled eight the sample included three Residents. All Residents of facility identified receiving the service medication management. Based on reviews of record and interviews, for three of three sampled (#189, #187, and #185), the Operator failed to ensure Residents received all medications and biologicals in accordance with a medical care provider written order and in accordance with professional standards of practice. Findings included: -Review of record revealed #185 admitted to facility 12/12/13 with diagnoses of Chronic anxiety, reactional depression, Constipation, Hypertension, Dementia, and High fall risk. The current 12/12/13 functional capacity screen assessed #185 unable to perform (3) medication and treatment management. The current 12/12/13 negotiated service agreement documented facility staff to administer all medications. Comparison of the current March 2014 MAR (medication administration record) with signed physician orders revealed a	S5300		

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S5300	Continued From page 3	S5300		

discrepancy:
Signed order dated 01/24/14 directed Guaifenesin ER (extended release) 600mg (milligrams) oral BID (twice daily) for two weeks for congestion. The January, February, March 2014 MAR ' s documented administration of the Guaifenesin from 01/24/14 to the present, the medication was not discontinued after two weeks as ordered.
On 3/05/14 at 2:12pm, the Residence Nurse confirmed the medication not administered as ordered.
The Operator failed to ensure all medications administered to #185 in accordance with a medical care provider ' s order.

-Review of record revealed #187 admitted to facility 5/23/13 with diagnoses of Dementia and Hyperlipidemia. The current 02/26/14 functional capacity screen assessed #187 unable to perform (3) medication and treatment management. The current 02/25/13 negotiated service agreement documented facility staff to administer all medications. Comparison of the current March 2014 MAR (medication administration record) with signed physician orders revealed a discrepancy:
Signed order dated11/07/13 directed Aricept 10mg (milligrams) po (by mouth) daily for dementia. The March 2014 MAR documented administration of Aricept 5mg daily.
On 3/05/14 at 4:52pm, the Residence Nurse confirmed the medication not administered as ordered ... verified the medication in the medication room being administered the 10mg tablets ... stated the order was never changed by the physician ... stated there was an error on the medication list update completed 12/02/13 the error was not caught, and was put on the MAR as 5mg, when should read 10mg ...

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S5300	Continued From page 4 The Operator failed to ensure all medications administered to #187 in accordance with a medical care provider ' s order. -Review of record revealed #189 admitted to facility 01/07/13 with diagnoses of Dementia, Anemia, Hypertension, Hypothyroidism, Chronic kidney disease, Glaucoma, and Stroke. The current 01/07/14 functional capacity screen assessed #189 unable to perform (3) medication and treatment management. The current 01/07/14 negotiated service agreement documented facility staff to administer all medications. Comparison of the current March 2014 MAR (medication administration record) with signed physician orders revealed a discrepancy: Signed order dated 01/30/13 directed Nystatin powder (antifungal) to [affected area] BID (twice daily) until clear then PRN (as needed). Signed order dated 12/13/13 directed Nystatin powder to [affected area] BID until clear. On 3/05/14 at 4:15pm, the Residence Nurse confirmed the medication order was transcribed to the MAR incorrectly ... the current order stated until clear then stop ... Residence Nurse stated the computer cut off part of the order on the 12/13/13 list of orders, and was not caught when the orders placed on the MAR. The Operator failed to ensure all medications administered to #189 in accordance with a medical care provider ' s order.	S5300		
S5380 SS=E	28-39-437 Plumbing and Piping Systems (i) Plumbing and piping systems. (1) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which	S5380		

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S5380	Continued From page 5 hoses or tubing can be attached. (2) Water distribution systems shall be arranged to provide hot water at hot water outlets at all times. The temperature of hot water shall range between 98° F and 120° F at showers, tubs, and lavatories accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 28-39-437 (i)(2) The census equalled eight the sample included three Residents. Based on observations and interviews, for one of two water heaters (supply for the East/South portion of facility), the Operator failed to ensure hot water at all outlets accessible to Residents remained between 98 and 120 degrees Fahrenheit (F). Findings included: By observations on 3/05/14 at 10:00am, temperatures at hot water outlets accessible to Residents were as follows: East Bathroom hand sink - 123.9 degrees F. West Bathroom hand sink - 118.4 degrees F. On 3/05/14 at 10:00am, Executive Director stated we have two water heaters in this building and we keep logs of temperatures checked monthly ... we have one wheelchair bound Resident, and one who ambulates in his/her room and uses a wheelchair outside of room, the remaining Residents are ambulatory around facility independently. Additional follow-up water temperatures obtained: 11:45am - Room #5 bathroom sink (also supplied by same water heater as the East Bathroom) - 125.9 degrees F. 11:47am - East Bathroom hand sink - 126.6 degrees F. 12:45pm - East Bathroom hand sink - 131.9 degrees F. At 12:45pm, Executive Director asked	S5380		

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S5380	Continued From page 6 Maintenance Staff to lower thermostat on hot water heater. Random observations between 11:00am and 1:00pm included sampled Resident #187 ambulating independently in and out of general living areas, hallway of East bathroom, and room #5. Surveyor and Executive Director each placed thermometers in a single glass of ice with some water. Surveyor ' s thermometer read 33.4 degrees F. and Executive Director ' s thermometer read 32 degrees F. 2:05pm - East Bathroom hand sink - 127.2 degrees F. 2:06pm - Room #5 bathroom sink - 127.0 degrees F. 2:15pm - Room #6 bathroom sink (also supplied by same water heater as the East Bathroom) - 132.4 degrees F. 2:30pm - East Bathroom hand sink - 132.4 degrees F. At 2:30pm, Executive Director stated I turned the thermostat down about 30 minutes ago; when I washed my hands and felt the water was still too hot, I am going down to lower the thermostat again. At 2:50pm, Executive Director stated I am going to let the water run, in an attempt to empty out some of the hot water and let it refill at the new adjusted lower temperature. At 3:00pm, Room #7 bathroom sink (also supplied by the same water heater as the East Bathroom and rooms #5 and #6) - 114.7 degrees F. The Operator failed to ensure the hot water temperature at all outlets accessible to Residents remained between 98 and 120 degrees F. at all times.	S5380		