STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059016	A. BUILDING: _____ B. WING _____	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MCPHERSON	1460 N MAIN STREET MCPHERSON, KS 67460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaint investigations #171577, #1717656, #172027, #172986, #177144 for the above named assisted living facility conducted on 01/03/23 and 01/04/23.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a)(1)(2)(3) The facility reported a census of 25 residents (R). The sample included three residents and two focused record reviews. Based on record review and interview, the executive director failed	S3085		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059016	A. BUILDING: _____ B. WING _____	01/04/2023

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S3085	Continued From page 1	S3085		

to ensure designated staff completed the Negotiated Service Agreement/Health Care Service Plan for three (R3, R4, R5) of three sampled residents based on the resident's "Functional Capacity Screen" and service needs, which included a description of the services the resident received, the provider of each service, and payment if the service is provided by an outside resource.

Findings included:

- Review of R3's medical record revealed he moved into the facility on 11/08/21 with diagnoses of hypertension and multiple sclerosis.

R3's "Functional Capacity Screen" dated 06/07/22 identified the resident required physical assistance with bathing and was at risk for falls.

R3's "Negotiated Service Agreement" (NSA) dated 06/07/22 revealed he requested physical assistance of one "staff" member with dressing and showering tasks completed with "staff" attention.

The NSA failed to identify "who" provided the assistance with bathing and dressing as not all facility "staff" are certified to provide physical assistance. The NSA also failed to include the resident received podiatry services, who provided the service, and payment source for the outside service.

On 01/04/23 at 11:43 AM "Certified Nurse Aide" B reported R3 called for help when he needed it and was mostly with putting on his boots and

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	N059016	A. BUILDING: _____ B. WING _____	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MCPHERSON	1460 N MAIN STREET MCPHERSON, KS 67460

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S3085	Continued From page 2	S3085		

buttoning shirts in the mornings.

On 01/04/22 at 11:18 AM "Licensed Nurse" D acknowledged the NSA did not identify that "certified" staff needed to provide the services or include the resident received podiatry services.

The executive director failed to ensure designated staff developed an NSA to address all identified service needs according the R3's "Functional Capacity Screen" and his service needs.

- R4's medical record revealed she moved into the facility on 01/03/20 with diagnoses of heart disease, type II diabetes mellitus and hypertension.

R4's "Functional Capacity Screen" dated 07/20/22 identified the resident required physical assistance with all activities of living except for eating. She required physical assistance for medications management and management of medical treatments. She had impaired cognition, was at risk for falls and had impaired vision.

R4's "Negotiated Service Agreement" (NSA) dated 07/20/22 revealed "associates to administer medications", "supervise blood sugar monitoring", "associates to prepare and dial insulin pen", and provide "staff attention" while resident performs insulin injection. For dressing, transfer, toileting, mobility the NSA identified assistance of one "associate".

The NSA failed to identify "who" provided assistance with medication administration, preparing the resident's insulin pen, supervision

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	N059016	A. BUILDING: _____ B. WING _____	01/04/2023

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S3085	Continued From page 3	S3085		

of self-injecting the pen and assistance with activities of daily living as not all facility "staff" are certified to provide physical assistance. . The NSA also failed to include the resident received podiatry services, who provided the service and who was responsible for payment of the service as it was an outside resource and failed to identify "Who" provided the resident Home Health services.

On 01/04/23 at 01:41 pm 'Certified Medication Aide" A reported the medication aides administer all the resident's medications including preparing her insulin pen and checking her blood sugars. The "Certified Nurse Aides" have to help her with dressing, bathing, peri-care, and all her transfers.

On 01/04/22 at 02:51 PM "Licensed Nurse" D acknowledged the NSA did not identify that "certified" staff needed to provide the services, does not say who the Home Health agency is, or include the resident received podiatry services

The executive director failed to ensure designated staff developed an NSA/HCSP to address all identified service needs according the R4's "Functional Capacity Screen" and her service needs.

- Review of R5's medical record revealed she moved into the facility on 09/14/22 with diagnoses of hypertension and low back pain.

R5's "Functional Capacity Screen" dated 09/14/22 revealed the resident needed supervision with bathing, was unable to manage her medications or medical treatments and had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059016	A. BUILDING: _____ B. WING _____	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MCPHERSON	1460 N MAIN STREET MCPHERSON, KS 67460

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S3085	Continued From page 4 bladder incontinence. R5's "Negotiated Service Agreement" (NSA) dated 9/14/22 revealed the resident requested assistance with her medications. The NSA failed to identify "who" provided assistance with medication administration as not all facility "staff" are certified to provide medication administration. The NSA also failed to identify the resident received podiatry services, who provided the services, and who was responsible for payment of the service since it is an outside resource. On 01/04/23 at 01:41 PM "Certified Medication Aide" A reported the medication aides give her medications, we help her with her showers and will call if she needs help with anything else. On 01/04/23 at 03:42 PM "Licensed Nurse" D acknowledged the NSA did not identify that "certified" staff needed to provide the services or include the resident received podiatry services The executive director failed to ensure designated staff developed an NSA/HCSP to address all identified service needs according the R5's "Functional Capacity Screen" and her service needs.	S3085		
S3165 SS=E	26-41-204 (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.	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059016	A. BUILDING: _____ B. WING _____	01/04/2023

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S3165	Continued From page 5 This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (d) The facility reported a census of 25 residents(R). The sample included three residents and two focused record reviews. Based on interview and record review the administrator failed to ensure two (R3 and R5) of three sampled resident's "Negotiated Service Agreement" included the name of the licensed nurse responsible for the implementation and supervision of the service plan. Findings included: - Review of R3's medical record revealed he moved into the facility on 11/08/21 with diagnoses of hypertension and multiple sclerosis. R3's "Functional Capacity Screen" dated 06/07/22 identified the resident required physical assistance with bathing and was at risk for falls. R3's "Negotiated Service Agreement" (NSA) dated 06/07/22 failed to identify the name of the licensed nurse responsible for the implementation and supervision of the nursing plan. - Review of R5's medical record revealed she moved into the facility on 09/14/22 with diagnoses of hypertension and low back pain. R5's "Functional Capacity Screen" dated	S3165		

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	N059016	A. BUILDING: _____ B. WING _____	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3165	Continued From page 6 09/14/22 revealed the resident needed supervision with bathing, was unable to manage her medications or medical treatments and had bladder incontinence. R5's "Negotiated Service Agreement" (NSA) Dated 9/14/22 failed to identify the name of the licensed nurse responsible for the implementation and supervision of the nursing plan. For R3 and R5, on 01/04/23 "Licensed Nurse" D reported acknowledged they did not include the name of the licensed nurse responsible for the implementation of the nursing plan. The executive director failed to ensure the name of the licensed nurse responsible for the implementation and supervision of the health care service plan was included in the negotiated service agreement.	S3165		
S3200 SS=F	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility.	S3200		

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	N059016	A. BUILDING: _____ B. WING _____	01/04/2023

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S3200	Continued From page 7 (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d)(1) The facility reported a census of 23 residents(R). The sample included three residents and two focused record reviews. Based on observation and interview the operator failed to ensure that only licensed nurses or certified medication aides administered and managed medications for which the home was responsible for one resident (R7) of two focused record reviews. Findings included: - Review of R7's medical record revealed she moved into the facility on 07/31/2016 with diagnoses of chronic obstructive pulmonary disease, heart failure, hypertension, and persistent pain. R7's "Functional Capacity screen" dated 07/07/22 identified the resident needed physical assistance with management of her medications and medical treatments. R7's "Negotiated Service Agreement" (NSA) dated 07/07/22 identified "associates" administered the resident's medications. The NSA did not identify who would administer medical treatments such as nebulizer breathing	S3200		

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	N059016	A. BUILDING: _____ B. WING _____	01/04/2023

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S3200	Continued From page 8 treatments. Review of a complaint investigation dated 05/11/22 revealed "Certified Medication Aide" (CMA) F had given R7's early morning medications to "Certified Nurse Aide" (CNA) G to administer. Per regulations only licensed nurses and certified medication aides shall administer and manage medications for which the facility is responsible. On 01/04/23 at 01:42 PM CMA A confirmed that a CNA was instructed by the CMA on duty to give medication to R7. Review of the resident's record for May 2022 revealed the following medications would have been given to her: PreserVision (eye supplement) Aspirin (blood thinner) Tablet 325 MG (milligrams) Lisinopril (blood pressure) Tablet 20 MG Metoprolol Tartrate (blood pressure) Tablet Give 12.5 mg Loratadine (seasonal allergies) Tablet 10 MG Spiriva HandiHaler (asthma) Capsule 18 MCG(milliequivelants) Tessalon Perles (cough) Capsule Potassium Chloride ER (supplement) Tablet Extended Release 10 MEQ Levothyroxine Sodium (thyroid) Tablet 25 MCG (micrograms) Ipratropium-Albuterol Solution (breathing treatment) 0.5-2.5 (3) MG/3ML (milligrams/milliliter) Review of witness statements obtained from the facility investigation revealed the following:	S3200		

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	N059016	A. BUILDING: _____ B. WING _____	01/04/2023

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S3200	Continued From page 9	S3200		

On 05/10/22 CMA A - reported that R7 had told him CNA G gave her medications yesterday morning and she drank her breathing treatment.

On 05/10/22 CMA F acknowledged she gave CNA G medications to administer to R7.

On 05/10/22 R7 reported CNA G handed her the medications and she drank her breathing treatment. The resident denied any ill effects from drinking the breathing treatment.

On 05/10/22 CNA G's statement revealed at approximately 05:30 AM on 05/09/22 she was at the medication cart with CMA F who asked her if she wanted to help give R7 her medications. CNA G reported she gave her all the medications in the cup and gave the breathing treatment to the resident to drink. When the resident told her the breathing treatment was supposed to go in the machine and she wasn't supposed to drink it, CNA G went and told CMA F what she had done. CMA F then took another breathing treatment to the resident and put it in the machine.

On 01/03/23 at 12:38 PM via phone interview "Administrative Staff" E acknowledged the above incident did occur, it was investigated immediately when it was reported, physician was notified and DPOA was notified.

On 01/04/23 at 09:17 AM "Administrative Licensed Nurse" H reported, upon assessing the resident, she had no adverse effects, and it was determined there was no abuse or neglect, just very poor judgement on the part of CMA F. The staff continued to monitor the resident for adverse effects and the CMA and CNA were

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	N059016	A. BUILDING: _____ B. WING _____	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3200	Continued From page 10 terminated. Review of the "Medication Administration" policy dated 05/2011 identified all licensed nurses can administer medications and delegate according to that states Nurse Practice Act. The agency should assure that medication management services are provided by qualified staff. The executive director failed to ensure only licensed nurses and certified medication aides administered medications for which the home was responsible. This failure resulted in a medication error for R7 and potentially all residents who were to receive medications from CMA F.	S3200		
S3227 SS=E	26-41-205 (l) (2) Medication Regimen Review Variance Report (l) (2) The licensed pharmacist or licensed nurse shall notify the medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist shall notify a licensed nurse within 48 hours of any variance identified in the resident ' s regimen review that does not require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident ' s medical care provider. The licensed nurse shall seek a response from the medical care provider within five working days of the medical care provider ' s notification of a variance.	S3227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059016	A. BUILDING: _____ B. WING _____	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MCPHERSON	1460 N MAIN STREET MCPHERSON, KS 67460

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S3227	Continued From page 11 This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (l)(2) The facility reported a census of 25 residents. The sample included three residents and two focused record reviews. Based on interview and record review the operator failed to ensure the licensed nurse informed the medical provider of medication regimen review variances for two (R4 and R5) of three sampled residents. Findings included: - Review of R4's medical record revealed she moved into the facility on 01/03/20 with diagnoses of heart disease and type II diabetes. Review of R4's progress notes included the following pharmacy notes: 05/04/2022 -Pharmacy Note- see report for irregularities 08/25/2022 -Pharmacy Note - see report for irregularities 11/15/2022 -Pharmacy Note -see report for irregularities Review of the resident's record lacked evidence of what the irregularities were and notification of the medical provider by the licensed nurse. On 01/04/23 at 02:47 PM "Licensed Nurse" D reported she had not seen any medication regimen reviews by the pharmacist since she started work in July of 2022. On 01/04/23 at 02:49 PM "Licensed Nurse" D stated she contacted the pharmacy and was told	S3227		

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	N059016	A. BUILDING: _____ B. WING _____	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MCPHERSON	1460 N MAIN STREET MCPHERSON, KS 67460

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S3227	Continued From page 12	S3227		

the pharmacist had been faxing them but would start emailing them to her. "Licensed Nurse" D acknowledged she had not sent anything to the physicians because she had not received the faxed reports.

The executive director failed to ensure the licensed nurse informed the medical provider of medication regimen review variances for R4.

- Review of R5's medical record revealed she moved into the facility on 09/14/22 with diagnoses of hypertension and low back pain.

Review of R5's progress notes included the following pharmacy note:
11/15/2022 - Pharmacy Note -see report for irregularities

Review of the resident's record lacked evidence of what the irregularities were and notification of the medical provider by the licensed nurse.

On 01/04/23 at 02:47 PM "Licensed Nurse" D reported she had not seen any medication regimen reviews by the pharmacist since she started work in July of 2022.

On 01/04/23 at 02:49 PM "Licensed Nurse" D stated she contacted the pharmacy and was told the pharmacist had been faxing them but would start emailing them to her. "Licensed Nurse" D acknowledged she had not sent anything to the physicians because she had not received the faxed reports.

The executive director failed to ensure the licensed nurse informed the medical provider of

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BROOKDALE MCPHERSON	1460 N MAIN STREET MCPHERSON, KS 67460

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S3227	Continued From page 13 medication regimen review variances for R5.	S3227		
S3261 SS=D	26-41-105 (f) (11) Resident Record 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 26-41-105(f)(11) The facility reported a census of 25 residents (R). The sample included three residents and two focused record reviews. Based on interview and record review the operator failed to ensure the record contained documentation of all incidents for one (R5) of three sampled residents. Findings included: - Review of R5's medical record revealed she moved into the facility on 09/14/22 with diagnoses of hypertension and low back pain. R5's "Functional Capacity Screen" dated 09/14/22 revealed the resident needed supervision with bathing, was unable to manage her medications or medical treatments and had bladder incontinence. R5's "Negotiated Service Agreement" (NSA)	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059016	A. BUILDING: _____ B. WING _____	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MCPHERSON	1460 N MAIN STREET MCPHERSON, KS 67460

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S3261	Continued From page 14 dated 09/14/22 revealed the resident requested assistance with her medications. Review of R5's progress notes and medical record lacked documentation of the resident moving into the facility on 09/14/22, including a nursing assessment of resident's condition upon arrival. On 01/04/23 at 03:53 PM "Licensed Nurse" D acknowledged the record did not include a nurses note for 09/14/22 when the resident moved into the facility. The executive director failed to ensure the R5's medical record included documentation of all incidents, including when she moved into the facility.	S3261		