STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087258	A. BUILDING: _____ B. WING _____	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERN'S PLACE	1730 N NORTHWEST PARKWAY WICHITA, KS 67212

(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 an Initial Licensure Survey for the above named facility conducted on 05/31/21, 06/01/23, and 06/05/23.	S 000		
S5080 SS=E	26-42-201 (a) (b) Functional Capacity Screen on Admission (a) On or before each individual ' s admission to a home plus, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the home, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(a) The facility reported a census of five residents (R). The sample included three residents and one focused record review. Based on interview and record review the operator failed to ensure two (R3 and R5) of three residents had their	S5080		

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

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S5080	Continued From page 1	S5080		

admission screening for determination of functional capacity completed on or before moving into the facility.

Findings included:

- Review of R3's Electronic Medical Record (EMR) revealed she moved into the facility on 07/14/22 with diagnoses of dementia and osteoporosis.

R3's record failed to include a "Functional Capacity Screen" (FCS) completed on or before admission to the facility. The only FCS in the EMR was completed on 05/02/23, 292 days after admission into the facility.

On 06/05/23 at 03:02 PM Administrative Staff A reported the FCS should be scanned into the EMR. The licensed nurse during that time would do things on paper and then scan them into the EMR.

The Operator failed to ensure designated staff completed the FCS for R3 on or before admission to the facility.

- Review of R5's Electronical Medical Record (EMR) revealed she moved into the facility on 04/03/23 with a diagnosis of cerebral infarction and congestive heart failure.

R5's EMR included a "Functional Capacity Screen" completed on 04/04/23, the day after she moved into the facility.

On 06/05/23 at 03:35 PM Administrative Staff A reported the "Functional Capacity Screens

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S5080	Continued From page 2 needed to be done on or before admission. The operator failed to ensure designated staff completed the "Functional Capacity Screen" for R5 on or before admission to the facility.	S5080		
S5095 SS=D	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(d) The facility reported a census of six residents (R). The sample included three residents and one focused record review. Based on observation, interview, and record review the operator failed to ensure designated staff completed one (R4) of three sampled resident's "Functional Capacity Screen" accurately to reflect the resident's functional ability regarding independence with activities of daily living. Findings Included: - Review of R4's Electronic Medical Record revealed she moved into the facility on 02/14/23 with diagnoses of congestive heart failure and hypertension.	S5095		

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S5095	Continued From page 3 R4's "Functional Capacity Screen" (FCS) dated 04/11/23 revealed the resident required physical assistance with dressing, toileting, and transfers. On 05/31/23 at 12:55 AM R4 got up from the table and walked to her room independently using her cane. She came back out a few minutes later and walked over to the recliner and sat in the recliner chair and put her feet up without staff assistance. On 06/01/23 at 10:52 AM Certified Medication Aide C reported the only thing they staff really need to do for her is give her medications and prepare her meals. She stated she can do most everything herself and we just provide supervision with showers. On 06/05/23 at 02:24 PM Certified Medication Aide G reported that R4 was pretty much independent. She will get up and take herself to the bathroom and dress herself in the mornings. On 06/05/23 at 03:20 PM Administrative staff A acknowledged R4's FCS was not accurate when it was completed on 04/11/23. The operator failed to ensure designated staff completed R4's FCS accurately regarding her need for assistance with activities of daily living.	S5095		
S5105 SS=F	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus 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	S5105		

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S5105	Continued From page 4	S5105		

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 26-42-202(a)(1)(2)

The facility reported a census of five residents(R). The sample included three residents and one focused record review. Based on interview, and record review for all residents, including three (R3, R4,R5) of three sampled residents the operator failed to ensure designated staff developed a "Negotiated Service Agreement" based on the resident's "Functional Capacity Screen" and the resident's service needs that included a description of the services the resident would receive and identification of the provider of each service.

Findings included:

- Review of R3s Electronic Medical Record revealed she moved into the facility on 07/14/22 with diagnoses of dementia and osteoporosis.

R3's "Functional Capacity Screen" (FCS) dated

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S5105	Continued From page 5	S5105		

05/02/23 identified the resident required physical assistance of staff for bathing, dressing, toileting, and management of medications. She was unable to manage her medical treatments, had bladder incontinence, was cognitively impaired and at risk for falls. R3 also had impaired decision making, wandered and inappropriate behaviors.

R3's "Negotiated Service Agreement" (NSA) dated 05/02/23 failed to include a description of services related to medical treatments, bladder incontinence, impaired cognition, impaired decision making, wandering, and inappropriate social behaviors. It also failed to identify the provider for each service.

On 06/01/23 at 02:02 PM Administrative staff A stated that all residents have the same format for their NSA. She also acknowledged that the NSA did not address all the services identified in the FCS.

The operator failed to ensure designated staff developed R3's NSA based on her FCS and service Needs that included a description of the services provided and who would provide each service.

- Review of R4's Electronic Medical Record revealed she moved into the facility on 02/14/23 with diagnoses of congestive heart failure and hypertension.

R4's "Functional Capacity Screen" (FCS) dated 04/11/23 revealed the resident required physical assistance with bathing, dressing, toileting, transfers, and management of medications. She

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S5105	Continued From page 6	S5105		

also could not manage her own medical treatments, had impaired cognition, impaired hearing and vision and had a current problem with falls/unsteadiness.

R4's NSA dated 02/14/23 failed to include a description of services for toileting, transfers, medical treatments, impaired cognition, problems with falls, impaired vision, and impaired hearing. It also failed to identify the provider for each service.

On 06/01/23 at 02:02 PM Administrative staff A stated that all residents have the same format for their NSA. She also acknowledged that the NSA did not address all the services identified in the FCS.

The operator failed to ensure designated staff developed R4's NSA based on her FCS and service Needs that included a description of the services provided and who would provide each service.

- Review of R5's Electronic Medical Record revealed she moved into the facility on 04/03/23 with diagnosis of congestive heart failure.

R5's "Functional Capacity Screen" dated 04/04/23 revealed the resident needed physical assistance with bathing, dressing, transfers, and toileting. It also identified the resident was unable to walk/be mobile, unable to manage her medications and medical treatments. R5 also had bladder incontinence, impaired cognition, a current problem, or risk for falls, wandering and impaired hearing.

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S5105	Continued From page 7 R5's "Negotiated Service Agreement dated 04/03/23 failed to include a description of services for dressing, transfers, walking/mobility, medical treatments, bladder incontinence, impaired cognition, falls, wandering and impaired hearing. On 06/01/23 at 02:02 PM Administrative staff A stated that all residents have the same format for their NSA. She also acknowledged that the NSA did not address all the services identified in the FCS. The operator failed to ensure designated staff developed R5's NSA based on her FCS and service Needs that included a description of the services provided and who would provide each service. This failure affected all residents in the facility because all had the same format and did not include descriptions of all services and who provided each service.	S5105		
S5115 SS=D	26-42-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-42-202 (c) The facility reported a census of five residents (R). The sample included three residents and one focused record review. Based on record review and interview the operator failed to	S5115		

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S5115	Continued From page 8 ensure the development of an initial negotiated service agreement upon admission to the facility for one (R3) of three sampled residents. Findings included: - Review of R3s Electronic Medical Record (EMR) revealed she moved into the facility on 07/14/22 with diagnoses of dementia and osteoporosis. R3's "Functional Capacity Screen" (FCS) dated 05/02/23 identified the resident required physical assistance of staff for bathing, dressing, toileting, and management of medications. She was unable to manage her medical treatments, had bladder incontinence, was cognitively impaired and at risk for falls. R3 also had impaired decision making, wandered and inappropriate behaviors. Review of R3's EMR lacked an initial "Negotiated Service Agreement" developed upon admission. On 06/05/23 at 2:31 PM Administrative Staff A reported the "Negotiated Service Agreements" are to be completed by the nurse upon admission to the facility. The operator failed to ensure designated staff developed an initial NSA at admission for R3.	S5115		
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	S5161		

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S5161	Continued From page 9 supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-42-204 (d) The facility reported a census of five resident (R)s. The sample included three residents and one focused record review. Based on interview for all residents and record review, the operator failed to ensure all residents including three (R3, R4, R5) of three sampled residents "Negotiated Service Agreements" included the name of the licensed nurse responsible for the implementation and supervision of the "Health Care Service Plan". Findings included: - Review of R3s Electronic Medical Record revealed she moved into the facility on 07/14/22 with diagnoses of dementia and osteoporosis. R3's "Functional Capacity Screen" (FCS) dated 05/02/23 identified the resident required physical assistance of staff for bathing, dressing, toileting, and management of medications. She was unable to manage her medical treatments, had bladder incontinence, was cognitively impaired and at risk for falls. R3 also had impaired decision making, wandered and inappropriate behaviors. R3's "Negotiated Service Agreement" (NSA) dated 05/02/23 failed to include the name of a licensed nurse responsible for the implementation and supervision of the resident's	S5161		

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S5161	Continued From page 10 "Health Care Service Plan". On 06/01/23 at 02:02 PM Administrative staff A stated that all residents have the same format for their NSA. She also acknowledged that the NSA did not include the name of the licensed nurse. The operator failed to include the name of the licensed nurse responsible for the implementation and supervision of R3's Health Care Service Plan in the NSA. - Review of R4's Electronic Medical Record revealed she moved into the facility on 02/14/23 with diagnoses of congestive heart failure and hypertension. R4's "Functional Capacity Screen" (FCS) dated 04/11/23 revealed the resident required physical assistance with bathing, dressing, toileting, transfers, and management of medications. She also could not manage her own medical treatments, had impaired cognition, impaired hearing and vision and had a current problem with falls/unsteadiness. R4's NSA dated 02/14/23 failed to include the name of a licensed nurse responsible for the implementation and supervision of the resident's "Health Care Service Plan". On 06/01/23 at 02:02 PM Administrative staff A stated that all residents have the same format for their NSA. She also acknowledged that the NSA did not include the name of the licensed nurse. The operator failed to include the name of the licensed nurse responsible for the	S5161		

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S5161	Continued From page 11 implementation and supervision of R4's Health Care Service Plan in the NSA. - Review of R5's Electronic Medical Record revealed she moved into the facility on 04/03/23 with diagnosis of congestive heart failure. R5's "Functional Capacity Screen" dated 04/04/23 revealed the resident needed physical assistance with bathing, dressing, transfers, and toileting. It also identified the resident was unable to walk/be mobile, unable to manage her medications and medical treatments. R5 also had bladder incontinence, impaired cognition, a current problem, or risk for falls, wandering and impaired hearing. R5's "Negotiated Service Agreement dated 04/03/23 failed to include the name of a licensed nurse responsible for the implementation and supervision of the resident's "Health Care Service Plan". On 06/01/23 at 02:02 PM Administrative staff A stated that all residents have the same format for their NSA. She also acknowledged that the NSA did not include the name of the licensed nurse. The operator failed to include the name of the licensed nurse responsible for the implementation and supervision of R5's Health Care Service Plan in the NSA.	S5161		
S5190 SS=F	26-42-206 (d) Dietary Services (d)(1) Menu plans shall be available to each resident on at least a weekly basis.	S5190		

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S5190	Continued From page 12	S5190		

This REQUIREMENT is not met as evidenced by:
KAR 26-42-206(d)(1)

The facility reported a census of five residents. Based on observation and interview the operator failed to ensure the menu plans were available to each resident on at least a weekly basis. This had the potential to affect all residents who lived int he facility.

Findings included:

- Observation on 05/31/23 at 01:09 PM during initial tour of the kitchen revealed a piece of notebook paper on the refrigerator that had the menu for Wednesday. Observation of other areas in the kitchen and bulletin boards did not have posting of a weekly or monthly menu for residents to review

On 05/31/23 at 01:15 PM Certified Medication Aide B reported Administrative Staff A currently had the menu notebook and working on getting it done for June.

On 05/31/23 at 01:24 PM Administrative staff arrived and stated they no longer use a company that had already prepared menus and they were working on doing their own based on what the resident's liked. She acknowledged she did not have the June menu completed at this time.

During the survey on 05/31/23, 06/01/23 and 06/05/23 the operator failed to have a weekly

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S5190	Continued From page 13 menu available for the residents. The operator failed to ensure the menu was planned and had it available for residents at least on a weekly basis.	S5190		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (e) The facility reported a census of five residents. Based on record review and interview, the operator failed to ensure staff prepared food using safe methods and ensured staff served foods at the proper temperature for all residents in the facility.	S5192		

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S5192	Continued From page 14 - On 05/31/23 at 01:15 PM Certified Medication Aide B reported the staff took the temperature of all hot foods and that record was kept in the food notebook. On 05/31/23 at 01:24 PM Administrative Staff A arrived at the facility with the food notebook. Administrative staff A looked in the notebook and reported they do not keep any type of food temperature log. Observation on 06/01/23 at 08:40 AM Certified Medication Aide (CMA) C put a pancake that was precooked and a couple of sausage patties in the microwave for a resident. She then went and assisted another resident who had an alarm go off and brought that resident to the table. At 08:48 AM CMA C then put food on two plates, removed the other plate from the microwave and put the other two in. She set the time, put on gloves, and when it stopped, she touched the food with her gloved hand to see if it was hot and she turned on the microwave for an additional minute. CMA C then removed the plates and put syrup on the pancakes and gave them to the residents without temping the food to ensure that it had been reheated to 165 degrees as according to the food safety code. The operator failed to have evidence to show foods are prepared and served at the proper temperatures.	S5192		
S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be	S5195		

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	B087258	A. BUILDING: _____ B. WING _____	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5195	Continued From page 15	S5195		

stored in the areas used for food storage, preparation, or serving.

(g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus.

This REQUIREMENT is not met as evidenced by:
KAR 26-42-206(f)

The facility reported a census of five residents. Based on observations and interview the operator failed to ensure staff stored all foods under safe and sanitary conditions.

Findings included:

- Observation on 05/31/23 at 01:09 during kitchen tour revealed the following food storage concerns.
In the main freezer were 3 baggies that had precooked sausage patties that had been taken out of the original packages. The baggies did not include a date they were taken out of the original package or a label on them.

On 05/31/23 at 01:12 PM Certified Medication Aide C stated they were brought up out of the freezer downstairs.

On 06/05/23 at 03:05 PM Administrative Staff A acknowledged when food is taken out of the original bag it needed to be dated and labeled.

The operator failed to ensure all foods were stored in a safe manner.

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S5215	Continued From page 16	S5215		
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 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 reported a census of five residents. Based on record review and interview for all residents and employees, the operator failed to ensure disaster and emergency preparedness by the failure to conduct quarterly reviews of the home's emergency management plan with employees and residents. Findings included: - On 05/31/23 at 01:57 PM while completing the entrance check list with Administrative Staff A, surveyor expressed the need to review records	S5215		

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S5215	Continued From page 17 to show the review of the facility's emergency management plan with residents and employees quarterly. Administrative staff A provided a notebook and turned to a page that followed the emergency plan. She stated that all the employees had to sign it that they had reviewed it and understand what they are supposed to do. Review of the information provided included the emergency management plan and had a signature page for employees. The Employees names were on the list only once and dates ranged from January to April of 2023. On 05/31/23 at 01:59 PM Administrative Staff A reported she did not have anything in writing to show reviews of the emergency management plan with residents and thought it only needed to be done when someone was hired or moved in and then again annually. Review of the undated "Emergency Preparedness Policy" and the "Emergency Action Plan" provided by Administrative Staff A did not include information regarding review of the plan with employees and residents. The operator failed ensure the review of the emergency management plan on a quarterly basis with all residents and all facility staff.	S5215		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer	S5230		

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S5230	Continued From page 18 infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: K.A.R 26-42-207(c) The facility reported a census of seven residents (R). The sample included three residents and one focused record review, and review of five newly hired employee files. Based on interview and record review for three (R3, R4, R5) of three sampled residents and five of five newly hired employees, the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Review of R3's medical record revealed she moved into the facility on 07/14/22. R3's medical record lacked a TB symptom screen and included only a one step TB skin test which was done 2 months after moving into the facility. - Review of R4's medical record revealed she moved into the facility on 02/14/23. R4's medical	S5230		

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S5230	Continued From page 19	S5230		

record lacked a TB symptoms screen completed on admission and her TB skin test was initiated 21 days after moving into the facility.

- Review of R5's medical record revealed he moved into the facility on 01/15/23. R5's medical record lacked completion of a TB symptoms screen and had only one TB skin test completed. Her two-step TB skin test was initiated 22 days after moving into the facility.

On 06/01/23 at 01:38 PM Administrative Staff A reported she thought the screen and skin testing was done on everyone and thought maybe it had been scanned into the electronic record incorrectly.

As of 06/05/23 at 11:44 AM Administrative Staff A had not provided evidence of appropriate TB skin testing for R3, R4, and R5.

Review of the "Tuberculosis Guidelines for Adult Care Homes" dated June 2013 revealed: Each new resident shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within 7 days of residency and shall receive a two-step tuberculosis skin test (TST) ... within seven days of residency.

The operator failed to ensure each new resident received a TB symptom screen and TB skin test according to the departments TB guidelines.

- Review of five newly hired employee files revealed the following:

Certified Medication Aide B, hired on 07/16/22

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S5230	Continued From page 20 did not have a TB symptom screen completed and did not have a two-step TB skin test completed within seven days of hire. Certified Nurse Aide D, hired on 01/20/23 did not have a TB symptoms screen completed, and had only a one TB skin test completed. Certified Medication Aide E, hired on 07/22/22 had a TB symptom screen completed, 41 days after hire date. Certified Medication Aide F hired on 02/02/23 had a two-step TB skin test completed, 29 days after hire date. Licensed Nurse G hired on 02/7/23 did not have a TB symptoms screen completed or a two-step TB skin test. On 06/05/23 at 03:44 PM Administrative Staff A reported she was a little confused as to when she needed to do the symptom screen or a TB skin test but would look in the employee files for any other TB information. As of 06/05/23 at 11:44 AM Administrative Staff A had not provided additional TB screens or TB skin testing for the five of five employees. Review of the facility's undated Tuberculosis policy revealed all personnel will be tested for TB according to the risk assessment identification for which personnel have potential exposure to TB and in accordance with federal, state, and/or local regulations. Review of the "Tuberculosis Guidelines for Adult	S5230		

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S5230	Continued From page 21 Care Homes" dated June 2013 revealed: Each new employee shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within 7 days of employment and shall receive a two-step tuberculosis skin test (TST) ... within seven days of employment. For five of five newly hired employees the operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S5230		
S5251 SS=E	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 facility reported a census of five residents (R). The sample included three residents and one focused record review. Based on interview and record review the operator failed to ensure the record contained documentation of all incidents, symptoms, and other indications of illness or injury including the time and date of occurrence, action taken, and results of the action for two (R3, R5) of three sampled residents.	S5251		

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S5251	Continued From page 22 Findings included: - Review of R3s Electronic Medical Record (EMR) revealed she moved into the facility on 07/14/22 with diagnoses of dementia and osteoporosis. R3's "Functional Capacity Screen" (FCS) dated 05/02/23 identified the resident required physical assistance of staff for bathing, dressing, toileting, and management of medications. She was unable to manage her medical treatments, had bladder incontinence, was cognitively impaired and at risk for falls. R3 also had impaired decision making, wandered and inappropriate behaviors. R3's "Negotiated Service Agreement" (NSA) dated 05/02/23 had marked the resident needed services for bathing, AM and PM preparation, toileting, and management of medications. Review of R3's EMR included the following observation notes: 08/24/22- had a minor fall in the activities room. She fell forward catching herself with her knees and elbows. She scrapped both elbows and has band aids on both accompanied by bruising on the knees. The record lacked follow up as to the resident fall and any injuries post fall. 05/31/23 - Aide reports resident fell early this morning around 2 AM. Resident was found on the floor in her room. Hospice was notified as well as family. Hospice nurse did an assessment on resident. No visible bruise or injury noted. Continue to monitor.	S5251		

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S5251	Continued From page 23 The record lacked follow up regarding resident status post fall. 06/01/23 - Seroquel 300mg discontinued as ordered. Staff left a message with call back number for provider to clarify if Seroquel 50mg should be continued. The record lacked follow up on resident status post medication change and no follow up from physician regarding the 50 mg Seroquel. On 06/05/23 at 03:12 PM Administrative Staff A stated she would expect someone to document a follow up after a fall as well as after having medication changes done. The operator failed to ensure designated staff documented results of actions taken post fall and after antipsychotic medication was discontinued. - Review of R5's Electronic Medical Record revealed she moved into the facility on 04/03/23 with diagnosis of congestive heart failure. R5's "Functional Capacity Screen" dated 04/04/23 revealed the resident needed physical assistance with bathing, dressing, transfers, and toileting. It also identified the resident was unable to walk/be mobile, unable to manage her medications and medical treatments. R5 also had bladder incontinence, impaired cognition, a current problem, or risk for falls, wandering and impaired hearing. R5's "Negotiated Service Agreement dated 04/03/23 had checked the resident needed services for bathing, toileting, and management of medications.	S5251		

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S5251	Continued From page 24 Review of R5's observation notes included the following: 04/21/2023 - Assessment done on resident, lung sounds diminished bilaterally, audible wheezing, BP 153/88, P78, R22 and slightly labored, T97.1, shortness of air with talking. medical provider notified and new order to obtain chest x-ray. 05/31/2023 - Resident re-admitted from [hospital] yesterday. The record lacked documentation of when and why the resident went to the hospital. On 06/05/23 at 03:30 PM Administrative Staff A stated she would expect someone to document in the record when and why a resident goes to the hospital. The operator failed to ensure designated staff documented when and why R5 went to the hospital. For R3 and R5, the operator failed to ensure the record contained documentation of all incidents, symptoms, and other indications of illness or injury including the time and date of occurrence, action taken, and results of the action.	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	S5258		

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S5258	Continued From page 25 specialized education or training; (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)(1) The facility reported a census of four residents. Based on record review and interview, the operator failed to provide evidence of registration, and certification check completion upon hire for five of five newly hired staff that required specialized education and training. This had the potential to affect all residents who resided in the facility. Findings included: - Review of five newly hired employee records revealed the following: Certified Medication Aide B, hired on 07/16/22	S5258		

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had a registry check completed but it did not include the auto printed date to show when staff checked to ensure Certified Medication Aide B had completed the required training to pass medications in the facility.

Certified Nurse Aide (CNA) D, hired on 01/20/23 did not have evidence of certification for training to work as a CNA.

Certified Medication Aide E, hired on 07/22/22 had a registry check completed but it did not include the auto printed date to show when staff checked to ensure Certified Medication Aide E had completed the required training to pass medications in the facility.

Certified Medication Aide F hired on 02/02/23 had a registry check completed but it did not include the auto printed date to show when staff checked to ensure Certified Medication Aide F had completed the required training to pass medications in the facility.

Licensed Nurse G hired on 02/07/23 had a licensure check completed on 06/01/23 three months after hire date.

On 06/01/23 at 09:38 AM Administrative Licensed Nurse A did not realize the registry checks needed to have a completion date on them. She acknowledged the registry checks needed to be completed when someone was hired.

The operator failed to ensure newly hired employee records contained evidence of registration/certification check upon hire.

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S5300 SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d) The facility reported a census of five residents (R). The sample included three residents and one focused record review. Based on interview and record review the operator failed to ensure that three (R3, R4, R5) of three sampled residents whom the facility was responsible for the administration of their medications were done so in accordance with a medical care provider's written order and according to professional standards of practice. Findings included:	S5300		

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- Review of R3s Electronic Medical Record revealed she moved into the facility on 07/14/22 with diagnoses of dementia and osteoporosis.

R3's "Functional Capacity Screen" (FCS) dated 05/02/23 identified the resident required physical assistance of staff for bathing, dressing, toileting, and management of medications. She was unable to manage her medical treatments, had bladder incontinence, was cognitively impaired and at risk for falls. R3 also had impaired decision making, wandered and inappropriate behaviors.

R3's "Negotiated Service Agreement" (NSA) dated 05/02/23 had marked the resident needed services for management of medications.

Review of R3's "Medication Administration Records" (MAR) from March 2023 to May 2023 included the following medication changes along with routine scheduled medications.
March 2023 MAR:
Seroquel (antipsychotic) 50 milligrams (mg) added to MAR on 03/07/23 for 01:00 PM and 09:00 PM. This was an increase in dosage from 25 mg (started on 01/03/23) to 50 mg.
Keflex (antibiotic) started on 03/07/23 and discontinued on 03/09/23
Macrobid (antibiotic) started on 03/15/23 and discontinued on 03/22/23
Macrodantin (antibiotic) started on 03/22/23 and discontinued on 03/23/23
Docusate Sodium (stool softener) started on 03/03/23 and discontinued on 03/14/23
Benadryl Allergy was initiated upon admission and discontinued on 03/02/23
Other medication included Quetiapine

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(antipsychotic) topical gel with a start dated of 02/13/23, Olanzapine (antipsychotic) scheduled and as needed with a start date of 08/14/22, Mirtazapine (antidepressant) with a start date of 08/18/22.

April 2023 MAR medication changes:
Acetaminophen (for pain) started on 04/28/23
Myrbetriq (overactive bladder) started on 04/12/23 and discontinued on 04/28/23
Melatonin started on 04/18/23

May 2023 MAR medication changes:
Lorazepam (antianxiety) started on 05/31/23
Dulcolax suppository started on 05/30/23
Vitamin D3 discontinued on 05/25/23
Simvastatin 20 mg discontinued on 05/25/23
Probiotic discontinued on 05/25/23
Olanzapine (antipsychotic) discontinued on 05/09/23
Mirtazapine (antidepressant) discontinued on 05/09/23
Melatonin discontinued on 05/09/23
Donepezil (Alzheimer's) discontinued on 05/09/23
Divalproex (mood stabilizer/anticonvulsant) started on 05/23/23 and increased on 05/30/23

On 06/01/23 at 02:02 PM discussed with Administrative Staff A inability to find written physician orders for the above scheduled and changed medication orders. Administrative Staff A stated she would have expected for all the orders to be scanned into the resident's electronic record and would look for them. She also stated she honestly was not sure what the prior nurse did with the orders after she inputted the information into the MAR.

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S5300	Continued From page 30 As of 06/07/23 at 09:00 AM Administrative staff A had not provided written signed orders for the start and discontinuation of the above listed medications. The operator failed to ensure R3's medications were administered according to a written physician's order and acceptable standards of practice. - Review of R4's Electronic Medical Record revealed she moved into the facility on 02/14/23 with diagnoses of congestive heart failure and hypertension. R4's "Functional Capacity Screen" (FCS) dated 04/11/23 revealed the resident required physical assistance with bathing, dressing, toileting, transfers, and management of medications. She also could not manage her own medical treatments, had impaired cognition, impaired hearing and vision and had a current problem with falls/unsteadiness. R4's "Negotiated Service Agreement" dated 02/14/23 had marked the resident needed services for management of medications. Review of R4's "Medication Administration Records" (MAR) from March 2023 to May 2023 included the following medication changes along with routine scheduled medications. March 2023 MAR: Spironolactone (diuretic) discontinued from routine to as needed on 03/03/23 Lasix (diuretic)discontinued form routine to as	S5300		

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needed on 03/03/23
K-Dur (potassium supplement) discontinued from routine to as needed on 03/10/23
Vitamin D3 started on 03/04/23
PreserVision started on 03/24/23
Lidocaine External Patch discontinued on 03/03/23
Diclofenac Sodium Gel (pain) discontinued on 03/21/23
Other routine medications included amlodipine (antihypertensive), Coumadin (anticoagulant), Omeprazole were initiated upon admission.
Medications started after admission included Fosamax started on 02/20/23, and Aspirin low dose started on 03/25/23

April 2023
Spironolactone as needed was discontinued and new order for routine dosage started on 04/26/23
K-Dur as needed was changed and routing dosage started on 04/26/23
Iron supplement was started on 04/26/23
Lasix as needed was discontinued and routing dosage started on 04/26/23
Amlodipine was decreased from 10mg daily to 5 mg daily.

May 2023
Coumadin 4 mg for 2 days started on 05/09/23
Coumadin 2 mg discontinued on 05/09/23
Coumadin 3mg started on 05/11/23
Atorvastatin discontinued on 05/02/23 and decreased dosage started.

On 06/01/23 at 02:02 PM discussed with Administrative Staff A inability to find written physician orders for the above scheduled and changed medication orders. Administrative Staff

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A stated she would have expected for all the orders to be scanned into the resident's electronic record and would look for them. She also stated she honestly was not sure what the prior nurse did with the orders after she inputted the information into the MAR.

As of 06/07/23 at 09:00 AM Administrative staff A had not provided written signed orders for the start and discontinuation of the above listed medications.

The operator failed to ensure R4's medications were administered according to a written physician's order and acceptable standards of practice.

- Review of R5's Electronic Medical Record revealed she moved into the facility on 04/03/23 with diagnosis of congestive heart failure.

R5's "Functional Capacity Screen" dated 04/04/23 revealed the resident needed physical assistance with bathing, dressing, transfers, and toileting. It also identified the resident was unable to walk/be mobile, unable to manage her medications and medical treatments. R5 also had bladder incontinence, impaired cognition, a current problem, or risk for falls, wandering and impaired hearing.

R5's "Negotiated Service Agreement dated 04/03/23 had checked the resident needed services for management of medications.

Review of R5's "Medication Administration Records" (MAR) for April and May of 2023 included the following medication changes along

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S5300	Continued From page 33 with routine scheduled medications. April MAR changes after admission date of 04/03/23: Voltaren gel (pain) apply as needed started on 04/18/23 Hydrocodone-Acetaminophen (narcotic pain med.) discontinued as needed on 04/18/23 and made routine. Colace (stool softener) changed from routine to as needed on 04/18/23 Acetaminophen discontinued on 04/18/23 Coumadin (anticoagulant) started on 04/22/23to give two tabs on Saturdays Tylenol arthritis pain started on 04/19/23 Tamsulosin started on 04/04/23 Omeprazole started on 04/04/23 Doxycycline (antibiotic) started on 04/28/23 MAY 2023 - Resident was out of the facility for skilled therapy the whole month of May. On 06/01/23 at 02:02 PM discussed with Administrative Staff A inability to find written physician orders for the above scheduled and changed medication orders. Administrative Staff A stated she would have expected for all the orders to be scanned into the resident's electronic record and would look for them. She also stated she honestly was not sure what the prior nurse did with the orders after she inputted the information into the MAR. As of 06/07/23 at 09:00 AM Administrative staff A had not provided written signed orders for the start and discontinuation of the above listed medications.	S5300		

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S5300	Continued From page 34 The operator failed to ensure R5's medications were administered according to a written physician's order and acceptable standards of practice.	S5300		
S5313 SS=F	26-42-205 (g) (3) Over the counter medication (g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(3) The facility reported a census of five residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on each package and/or bottle of over-the-counter medications. Findings included: - Observation on 05/31/23 at 02:49 PM Certified	S5313		

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S5313	Continued From page 35 Medication aide C unlocked the medication cart for inspection. Observation of the medication cart included the following over-the counter medication without a resident name and some were labeled "stock". It included a bottle of Bayer low dose aspirin, bag with Tylenol suppositories, box of Loperamide, box of Zofran, bottle of stool softener, Cepacol sore throat lozenges, bottle of Acetaminophen, bottle of Milk of Magnesia, bottle of Miralax, bottle of Vitamin D3. Certified medication Aide C stated all of the above medications could be use by any resident in the facility who had a physician's order for it. The medication also included a box of Miralax in packets with a resident's first name only. The operator failed to ensure the residents' full names were on each bottle of over-the-counter medications.	S5313		
S5314 SS=D	26-42-205 (g) (4) Sample & Indigent Medication Program Meds (g) (4) Licensed nurses and medication aides may administer sample medications and medications from indigent medication programs if the administrator or operator ensures the development of policies and implementation of procedures for receiving and identifying sample medications and medications from indigent medication programs that include all of the following conditions: (A) The medication is not a controlled medication. (B) A medical care provider ' s written order accompanies the medication, stating the resident ' s name; the medication name, strength, dosage,	S5314		

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S5314	Continued From page 36 route, and frequency of administration; and any cautionary instructions regarding administration. (C) A licensed nurse or medication aide receives the medication in its original, unbroken manufacturer ' s package. (D) A licensed nurse documents receipt of the medication by entering the resident ' s name and the medication name, strength, and quantity into a log. (E) A licensed nurse places identification information on the medication or package containing the medication that includes the medical care provider ' s name; the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider ' s order. Staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches the information on the medical care provider ' s order. (F) A licensed nurse informs the resident or the resident ' s legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies. The resident ' s clinical record shall contain documentation that the resident or resident ' s legal representative has received the information and accepted the risk of potential adverse consequences. This REQUIREMENT is not met as evidenced by:	S5314		

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S5314	Continued From page 37 KAR 26-42-205(g)(4)(B)(D)(E)(F) The facility reported a census of five residents (R). The sample included three residents and one focused record review. Based on observation, interview and record review the operator failed to ensure one (R6) of one resident that received sample medications included the following: 1. a care providers writeten order with the medication that included the name, strength, dosage, route, and frequency of administration and any cautionary instructions; 2. License Nurse document receipt of medication with appropriate information into a log; 3. Licensed Nurse failed to included required information on each box/container and indicate verification of such information.; 4. A licensed nurse failed to inform the resident or resident's legal representative the medications were not received through a pharmacy and were not reviewed by a pharmacist. Findings included: - Review of R6's medical record revealed he moved into the facility on 04/07/23 with diagnosis of prostate cancer. R6's "Functional Capacity Screen" dated 04/07/23 identified the resident was unable to manage his medications or medical treatments. R6's undated "Negotiated Service Agreement" had marked he needed medication management services. On 05/31/23 at 02:49 PM Certified Medication Aide (CMA) C unlocked the medication cart for	S5314		

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S5314	Continued From page 38 inspection. Observation revealed a bottle of Nubequ (prostate cancer medication) 300 milligrams without a pharmacy prescription label or a resident name on it. The medication drawer also did not include a written physician's order for the medication. CMA C stated the medication was for R6. CMA C did not have any additional paperwork related to R6 using sample medications. On 05/31/23 at 04:00 PM Administrative staff A reported she did not realize anyone had sample medications in the facility and did not know of any additional paperwork for using it. Review of the undated "Sample Medication" policy revealed the following: The Designated staff person ensures that all sample medications received into the community are provided by the prescribing physician. Sample medications will be labeled with all the information required on any prescription label except pharmacy name and prescription number. Sample medications are centrally stored, documented, and handled in the same manner as other prescription medications. The operator failed to ensure the appropriate information regarding the administration of sample medications for R6 was received when brought into the facility, including a written physicians order with specified instructions and any cautionary instructions, the license nurse document receipt of medication with appropriate information into a log and write the appropriate information on the bottle, along with verification from another licensed nurse or medication aide to verify such information. The operator also	S5314		

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S5314	Continued From page 39 failed to include information that the resident and/or legal representative was informed the medications were not received through a pharmacy and not reviewed by a pharmacist.	S5314		
S5315 SS=E	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	S5315		

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S5315	Continued From page 40 expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h)(4) The facility reported a census of five residents. Based on observation and interview the Operator failed to ensure Tuberculin solution was not accidentally administered beyond the manufacturers or pharmacy recommended date of expiration. Findings included: - On 05/31/23 at 01:31 PM the refrigerator had a locked box secured in the side of it. Certified Medication Aide C opened the box and it had a vial of Tuberculin solution and syringes. The TB vial had a opened date of 03/07/23. Review of the newly hired employee list revealed that 3 employees were hired after 04/07/23 who still worked at the facility and should have received TB skin testing upon hire. On 05/31/23 at 01:31 Administrative Staff A acknowledged the date on the Tuberculin solution was more than 30 days past. Tuberculin manufacturer guidelines directions for storage include to date the tuberculin vial when opening and discard it after 30 days. The operator failed to ensure Tuberculin solution was stored to ensure that it was not accidentally	S5315		

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S5315	Continued From page 41 administered beyond the manufacturers or pharmacy' recommended date of expiration.	S5315		
S5325 SS=D	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 reported a census of five residents(R). The sample included three residents and one focused record review. Based on interview and record review for one(R3) of 3 sampled residents, the operator failed to ensure a licensed pharmacist or licensed nurse conducted a medication regiment review at least quarterly for each resident whose medication the facility managed. Findings included: - Review of R3s Electronic Medical Record revealed she moved into the facility on 07/14/22 with diagnoses of dementia and osteoporosis. R3's "Functional Capacity Screen" (FCS) dated	S5325		

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S5325	Continued From page 42 05/02/23 revealed the resident required physical assistance with management of medications. R3's "Negotiated Service Agreement" (NSA) dated 05/02/23 revealed the resident required services for management of medications. Review of the pharmacy reviews provided by Administrative Staff A revealed R3 had medication regimen reviews conducted on 01/06/23 and 05/05/23. The record lacked evidence that the resident had a medication regimen review conducted between 07/14/22 and 01/06/23. As of 06/06/23 at 06:24 PM Administrative Staff A had not provided additional pharmacy reviews for R3. The operator failed to ensure each residents medication regimen was reviewed at least quarterly by a licensed pharmacist or licensed nurse.	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	S5326		

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S5326	Continued From page 43 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 facility reported a census of five residents(R). The sample included three residents and one focused record review. Based on interview and record review for two (R3, R4,) of three sampled residents for whom the facility was responsible for administering their medications, the operator failed to ensure the medication regimen review included identification of irregularities related to lack of clinical indication for use of medications. Findings included: - Review of R3s Electronic Medical Record revealed she moved into the facility on 07/14/22 with diagnoses of dementia and osteoporosis. R3's "Functional Capacity Screen" (FCS) dated 05/02/23 identified the resident required physical assistance with management of her medications. R3's "Negotiated Service Agreement" (NSA) dated 05/02/23 had checked the resident needed services for medication of medications. Review of R3's pharmacy review dated 01/06/23	S5326		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087258	A. BUILDING: _____ B. WING _____	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERN'S PLACE	1730 N NORTHWEST PARKWAY WICHITA, KS 67212

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S5326	Continued From page 44	S5326		

identified no irregularities. The pharmacy review dated 05/05/23 included a physician recommendation but did not identify any concerns related to lack of clinical indication for use.

Review of R3's physician orders effective on 05/05/23 included the following medications without clinical indication of use:
Alendronate Sodium (a bone resorption inhibitor), Donepezil HCL (Alzheimer's therapy), Fiber Gummy, Mirtazapine (antidepressant), Olanzapine (antipsychotic), Probiotic, Simvastatin (lipid-lowering medication), and Vitamin D3.

On 06/05/23 at 12:11 PM Licensed Pharmacist I reported she did not catch medications without indications for use but that is something she would normally address.

The operator failed to ensure the medication regimen review included identification of irregularities related to the lack of clinical indication for use of each medication.

- Review of R4's Electronic Medical Record revealed she moved into the facility on 02/14/23 with diagnoses of congestive heart failure and hypertension.

R4's "Functional Capacity Screen" (FCS) dated 04/11/23 revealed the resident required physical assistance with management of medications.

R4's "Negotiated Service Agreement" dated 02/14/23 had checked the resident needed services for medication management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087258	A. BUILDING: _____ B. WING _____	06/05/2023

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S5326	Continued From page 45 Review of R4's medication regimen review dated 05/05/23 did not identify any physician recommendations related to irregularities such as medications without a clinical indication for use. Review of R4's physician orders effective on 05/05/23 included the following medications without a clinical indication for use: Aspirin low dose, Atorvastatin Calcium (Antihyperlipidemic), Coumadin (anticoagulant), Fosamax (bone resorption inhibitor), Omeprazole (gastric acid reducer), and Tylenol extra strength. On 06/05/23 at 12:11 PM Licensed Pharmacist I reported she did not catch medications without indications for use but that is something she would normally address. The operator failed to ensure the medication regimen review included identification of irregularities related to the lack of clinical indication for use of each medication.	S5326		
S9999	Final Observations KAR 26-42-103(c) Staff Development (c) If the home plus admits residents with dementia, the administrator or operator shall ensure the provision of staff education, at orientation and at least annually thereafter, on the treatment and appropriate response to persons who exhibit behaviors associated with dementia.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087258	A. BUILDING: _____ B. WING _____	06/05/2023

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S9999	Continued From page 46 (Authorized by and implementing K.S.A. 39-932; effective Oct. 14, 2011.) This Requirement is not met as evidenced by: Scope and Severity of E The facility reported a census of five residents (R) and identified two residents with cognitive impairment. Review of the two resident electronic medical records recorded diagnoses of dementia and/or Alzheimer's disease. Based on interview and record review for five newly hired staff and all staff currently in the facility the operator had not ensured the provision of dementia training for staff education. Findings included: On 06/05/23 at 04:00 PM Administrative staff had not been able to find specific evidence of staff having dementia training. She reported there are a lot of things that we go over in our in-services and training and thought May was when we did the dementia training. She was not able to provide evidence of having an Inservice in May for dementia training. As of 06/07/23 at 09:12 PM Administrative Staff A had not provided evidence of providing dementia training upon orientation for employees and annually thereafter. The operator failed to ensure the provision of staff orientation and in-service education on the treatment and appropriate responses to residents regarding dementia training.	S9999		