

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/10/2023
NAME OF PROVIDER OR SUPPLIER ANTHOLOGY OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 151ST STREET OLATHE, KS 66061		
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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints #179303, #179207, #176534, #174776, and #168842 at the above named assisted living facility conducted on 08/08/23 - 08/10/23.	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) The facility reported a census of 71 residents with seven residents included in the sample and two closed record reviews. Based on interview and record review the administrator failed to	S3085		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3085	Continued From page 1 ensure the "Negotiated Service Agreements" (NSA) for Residents (R) 3, R7, and R2 described the services they would receive based on their "Functional Capacity Screens" (FCS). R3 was assessed at high risk for falls and fell on 12/02/22 hitting her head. She was sent to the hospital for evaluation and was found to have a brain bleed. Findings included: - Record review for R3 revealed an admission date of 03/18/21 with diagnoses of diabetes and arthritis. The 12/06/22 "FCS" identified R3 was unable to perform transfers; required physical assistance with walking/mobility; and was marked for falls. The 05/25/22 (before the fall incident) "KS Wellness Assessment Results", under the section for falls, documented R3 assessed at "high potential for falls" but failed to identify the services provided to prevent injury from falls. The 12/06/22 (after the fall incident) "KS Wellness Assessment Results" identified facility staff would provide routine hands-on assistance with two persons utilizing a mechanical lift for transfers and hands on assistance with a wheelchair for walking/mobility. The falls section of the "NSA/HSP" documented R3 assessed at "high potential for falls" but failed to identify the services provided to prevent injury from falls. The 12/08/22 facility's investigation submitted to the department documented R3 was being assisted to transfer by two staff utilizing a mechanical lift. Staff reported R3 let her hands	S3085		

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S3085	Continued From page 2 off the bar and slid out of the sling hitting her head on the floor. The resident was transported to the hospital. On 12/03/22 the hospital reported R3 had a small brain bleed in the back of her head. - Record review for R7 revealed an admission date of 04/29/21 with a diagnosis of Alzheimer's disease. The 12/08/22 "FCS" identified R7 required physical assistance with transfers and was rarely or never understandable and sometimes understood others during communication. The 12/07/23 "KS Wellness Assessment Results" failed to identify the services staff provided R7 for transfers and communication. - Record review for R2 revealed an admission date of 08/31/19 with diagnoses of cerebrovascular accident, muscle weakness, and shortness of breath. The 04/28/23 "FCS" identified R2 required supervision with transfers and was marked for falls. The 04/28/22 "KS Wellness Assessment Results" failed to identify the services provided for transfers and to prevent injury from falls. On 08/09/23 at 09:39 AM Administrative Staff A stated the "KS Wellness Assessment Results" was the "NSA" and "HSP" combined in one document. On 08/10/23 at approximately 11:03 AM Administrative Nurse B confirmed R3's "NSA"	S3085		

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S3085	Continued From page 3 failed to identify the services provided to prevent injury from falls; R7's "NSA" failed to identify the services provided for transfers, and communication; and R2's "NSA" failed to identify the services provided to prevent injury from falls. The administrator failed to ensure the "NSAs for R3, R7, and R2 described the services they would receive based on their "Functional Capacity Screens" (FCS).	S3085		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (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 26-41-205 (g)(3) The facility reported a census of 49 residents who lived in the assisted living and 22 residents who lived in the memory care unit. Based on observation and interview the administrator failed	S3211		

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S3211	Continued From page 4 to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of eight over-the-counter (OTC) medications on a medication cart in the assisted living. Findings included: - Observation on 08/08/23 at 10:23 AM revealed Certified Medication Aide (CMA) C unlocked and opened the assisted living first floor medication cart. The following OTC medications were not labeled with residents' full names: One bottle of Vitamin B12 5,000 micrograms (mcg), 300 tablets One bottle of Preservision Areds 2, 140 softgels One bottle of Caltrate Bone Health 600 +D3, 200 tablets One bottle of magnesium 400 milligrams (mg), 75 softgels One bottle of Lactaid, 32 tablets One bottle of acetaminophen 500 mg, 200 caplets One bottle of docusate sodium stool softener 100 mg, 50 softgels One bottle of melatonin 3 mg, 120 tablets On 08/08/23 at approximately 10:23 AM CMA C confirmed the OTC medications were not labeled with resident's full names. The facility's revised 02/2022 "Medication Storage of Centrally Stored Medications" policy documented "Medications will be stored in a manner that ensures maintenance of both the integrity of the medication and the safety of all residents residing in the Community."	S3211		

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S3211	Continued From page 5 The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of OTC medications.	S3211		
S3215 SS=E	26-41-205 (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 facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility 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 facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer '	S3215		

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S3215	Continued From page 6 s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h) The facility reported a census of 71 residents. Based on observation and interview, the administrator failed to ensure medications were stored in accordance with each manufacturer's recommendations. Findings included: - Observation on 08/08/23 at 09:53 AM revealed the facility's medication room had a refrigerator with an opened box with an unsealed vial of Tuberculin that was not marked with the opened date. - The box and the vial of Tuberculin contained instructions that a vial of Tuberculin which had been opened for 30 days should be discarded. - On 08/08/23 at approximately 09:53 AM Certified Medication Aide (CMA) D confirmed the Tuberculin vial was opened and not dated. - On 08/08/23 at 02:18 PM Administrative Nurse B confirmed the Tuberculin vial was opened and not dated. - The administrator failed to ensure medications were stored in accordance with each manufacturer's recommendations.	S3215		

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ANTHOLOGY OF OLATHE

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OLATHE, KS 66061**

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