STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089082	A. BUILDING: _____ B. WING _____	11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #2	618 SW OAKLEY AVENUE, SUITE B TOPEKA, KS 66606

(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 represents the findings of a Re-Licensure survey with complaint investigations 174056 at the above named Home Plus facility conducted on 11/27/23 and 11/28/23.	S 000		
S5095 SS=E	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 11 residents (R). The sample included three residents and one focused review. Based on observation, interview, and record review the operator failed to ensure designated staff completed three (R3, R4, R5) of three sampled resident's "Functional Capacity Screen" accurately to reflect the resident's functional ability. Findings Included: - Review of R3's medical record revealed she moved into the facility on 07/26/23 with diagnoses of dementia and diabetes mellitus type II. R3's "Functional Capacity Screen" (FCS) dated	S5095		

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

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S5095	Continued From page 1 07/24/23 revealed the resident could not participate in the task of walking or mobility. On 11/27/23 at 11:37 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" were one document (NSA/HCSP). R3's NSA/HCSP dated 7/26/23 revealed the resident used a wheelchair or Broda chair (specialized wheelchair) for mobility. On 11/27/23 at 01:31 PM Certified Nurse Aide (CNA) E reported R3 needed two staff to transfer into her Broda chair and bring her out for meals. On 11/28/23 at 08:10 AM Certified Medication Aide (CMA) F reported when R3 first came she had no energy and was weak. Staff had to transfer her into a wheelchair to bring her out for meals and activities. On 11/28/23 at 02:26 PM CMA G reported when R3 first came she was in a wheelchair and then got the Broda chair. Staff transfer her out of bed to the chair and bring her out to the dining room for meals. On 11/28/23 at 01:19 PM Administrative Licensed Nurse B reported she marked walking/mobility a "3" because R3 is not able to walk, and she doesn't get herself up. On 11/28/23 at 11:40 AM, Administrative Licensed Nurse B provided the "Resident Functional Capacity Screen Manual" Updated July 11, 2008, as part of their policy for completion of the FCS. Review of the manual	S5095		

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S5095	Continued From page 2	S5095		

revealed a resident's ability to function may vary over the course of a day and needed to be coded for the lowest level of functioning. Directions for Walking/Mobility included to use code "3" for residents who are bedfast and do not use a wheelchair or other mobility device.

The operator failed to ensure designated staff coded R3's FCS accurately upon admission.

- Review of R4's medical record revealed he moved into the facility on 10/23/23 with diagnoses of orthostatic hypotension and history of a stroke.

R3's "Functional Capacity Screen" (FCS) dated 10/23/23 revealed the resident needed physical assistance with toileting and was continent of bladder.

On 11/28/23 at 01:14 PM R4 stated that he doesn't get up to use the toilet or urinal because whenever he gets up his blood pressure drops really low. He reported that he calls the staff to come in and change him whenever he urinates.

On 11/27/23 at 01:35 PM Certified Nurse aide E reported R4 just rang for staff to come in and change his brief after he urinates.

On 11/28/23 at 08:12 AM Certified Medication Aide F reported R4 did not get up to use the toilet or commode he just called for us to change him when he was done.

On 11/28/23 at 09:06 AM CMA F and CNA E both confirmed that since R4 has been at the facility he had been incontinent, and they had not gotten

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him out of bed to use the toilet. CMA F stated therapy had gotten him up once and since then he had refused to get up and just calls staff to come and change him.

On 11/28/23 at 02:25 PM Certified Medication Aide (CMA) G reported R4 is mostly bed bound but gets up for one shower per week. CMA G stated since he has lived here, he calls staff to come and change him after he gets done going in his brief.

On 11/28/23 at 12:34 PM Administrative Licensed Nurse stated she coded toileting and bladder incontinence the way she did because he knows when he needs to use the bathroom, he just chooses to go in his brief. She also stated he does better in the evenings and believed there had been times when he got up to use the restroom and the urinal on second shift. Administrative Licensed Nurse did acknowledge that the FCS should have at least identified the resident was incontinent of bladder.

On 11/28/23 at 11:40 AM, Administrative Licensed Nurse B provided the "Resident Functional Capacity Screen Manual" Updated July 11, 2008, as part of their policy for completion of the FCS. Review of the manual revealed a resident's ability to function may vary over the course of a day and needed to be coded for the lowest level of functioning. Directions for Toileting indicate to code for how the resident uses the toilet or commode, bed pan or urinal, including transfers on and off. For "Bladder Continence" related to the loss of urine should be coded a four if the resident had multiple episodes of incontinence daily.

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S5095	Continued From page 4	S5095		

The operator failed to ensure designated staff completed R4's FCS accurately to identify his incontinence and need for assistance with all aspects of toileting.

- Review of R5's medical record revealed she moved into the facility on 01/29/21 with diagnoses of anxiety disorder and myelodysplastic syndrome (a type of cancer).

Review of R4's Functional Capacity Screen dated -5/17/23 revealed the resident was unable to participate in the task of walking/mobility.

On 11/27/23 at 11:37 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement", and the "Health Care Service Plan" were one document (NSA/HCSP).

R4's NSA/HCSP dated 05/18/23 revealed the resident could propel herself in the wheelchair.

Observation on 11/28/23 at 09:56 AM the resident sat in the wheelchair at her desk. She then propelled herself to her dresser and got a small notebook out for the surveyor to look at.

On 11/27/23 at 01:20 PM the resident reported she could still take herself down to the dining room in her wheelchair.

On 11/28/23 at 02:24 PM Certified Medication Aide G reported the resident will propel herself throughout the facility without staff assistance.

On 11/28/23 at 01:19 PM Administrative Licensed Nurse B reported she marked

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S5095	Continued From page 5 walking/mobility a "3" because R5 is not able to walk, and she doesn't get herself up. On 11/28/23 at 11:40 AM, Administrative Licensed Nurse B provided the "Resident Functional Capacity Screen Manual" Updated July 11, 2008, as part of their policy for completion of the FCS. Review of the manual revealed a resident's ability to function may vary over the course of a day and needed to be coded for the lowest level of functioning. Directions for Walking/Mobility included to use code "3" for residents who are bedfast and do not use a wheelchair or other mobility device. The operator failed to ensure designated staff coded R5's FCS accurately.	S5095		
S5185 SS=D	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian.	S5185		

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S5185	Continued From page 6 This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (c) The facility reported a census of 11 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 (R4) of one sampled residents record who received a therapeutic diet included approved instructions from a medical care provider or licensed dietitian on how to prepare R4's pureed diet. Findings included: -- Review of R3's medical record revealed she moved into the facility on 07/26/23 with diagnoses of dementia and diabetes mellitus type II. R3's "Functional Capacity Screen" (FCS) dated 07/24/23 revealed the resident needed physical assistance with eating. On 11/27/23 at 11:37 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement", and the "Health Care Service Plan" were one document (NSA/HCSP). R3's NSA/HCSP dated 7/26/23 revealed the resident had a pureed diet with thickened liquids, used an adaptive spoon and fork and required full assistance with feedings. Review of R3's signed physician orders dated 07/24/23 directed staff to provide a pureed diet with nectar thickened liquids.	S5185		

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S5185	Continued From page 7 Review of the menu notebook included directions on the back of the daily menu instructions for how to make the menu pureed consistency. The notebook did not include approved instructions from the residents medical provider or a licensed dietitian. Review of R3's chart did not have a physician or licensed dietitian instructions for how to prepare pureed foods. On 11/28/23 at 01:46 PM Administrative Licensed Nurse B provided a Diet guideline notebook and said the approved instructions should be in it. Review of the notebook included signatures from a medical provider back in 2018 for limited concentrated sweet, mechanical soft protocol and no added salt diet. It did not include a medical provider or licensed dietitians' approval of instructions for preparing a pureed diet. On 11/28/23 at 01:49 PM Administrative Licensed Nurse B looked at the Diet Guideline notebook and acknowledged it did not include instructions for preparing pureed foods by a medical provider or a licensed dietitian. Review of the undated "Diet Protocol" provided by Administrative Licensed Nurse B on 11/28/23 revealed the physician or dietitian may review and adopt the facilities protocol for special diets. If the physician determines the facilities special diet protocol is sufficient they must specify in writing the facilities dietary protocol is appropriate for the resident.	S5185		

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S5185	Continued From page 8 The operator failed to ensure designated staff obtained approval for instructions from the medical provider or a licensed dietitian for preparing a pureed diet.	S5185		
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 11 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. - On 11/27/23 at 10:44 AM Certified Medication	S5192		

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S5192	Continued From page 9 Aide (CMA) D Provided the current food temperature log from the side of the refrigerator and reported the rest of the food temperature logs were in the notebook and handed the surveyor the log notebook. Review of the notebook revealed the following concerns for October and November: October had 21 days with no food temperatures for the supper meals; three days with no food temperatures for all three meals served; and two days with no food temperatures for breakfast and lunch. November had 11 days with no food temperatures for all three meals and three days with no food temperatures for the supper meals. On 11/27/23 at 10:44 AM CMA D reported whoever is cooking the meal is supposed to take the temperature of the foods before they serve them. On 11/27/23 at 04:19 PM Administrative Licensed Nurse B acknowledged staff were supposed to take the temperature of all foods when they are done cooking it and before they serve it. Review of the undated "Diet Protocol" provided by Administrative Licensed Nurse B revealed staff shall serve food at the proper temperature and included to cook all ground meats to 160 degrees Fahrenheit (F) and poultry to 165 F. Hot foods should be held at 140 degrees or warmer and cold foods should be held at 40 F or colder.	S5192		

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S5192	Continued From page 10 The operator failed to have evidence to show foods are prepared and served at the proper temperatures.	S5192		
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 11 residents. Based on record review and interview the operator failed to ensure disaster and emergency preparedness by the failure to conduct quarterly reviews of the home's emergency management plan with all residents. Findings included:	S5215		

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S5215	Continued From page 11 - On 11/27/23 at 11:52 AM Administrative Licensed Nurse B reported the facility staff talked to the residents before the drills so that they knew what was happening, but they did not have anything in writing for reviewing the required emergency plans with the residents. The operator failed to ensure disaster and emergency preparedness by the failure to conduct quarterly reviews of the emergency management plan with all residents.	S5215		
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 11 residents (R). The sample included three residents and one focused record review. Based on interview and record review the operator failed to ensure the medical record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date and time, action taken, and results of the action for three (R3, R4, and R5) of three sampled residents. Findings included:	S5251		

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S5251	Continued From page 12 - Review of R3's medical record revealed she moved into the facility on 07/26/23 with diagnoses of dementia and diabetes mellitus type II. R3's "Functional Capacity Screen" (FCS) dated 07/24/23 revealed she had impaired cognition and was unable to participate in management of her medications and medical treatments. On 11/27/23 at 11:37 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" were one document (NSA/HCSP). R3's NSA/HCSP dated 07/26/23 revealed the facility Certified Medication Aides and Licensed Nurses administered medications and medical treatments and were to anticipate the residents needs. Review of R3's medical record included the following documentation in the nursing progress notes from 08/15/23 to 11/27/23: The documentation included eight entries without a time documented, and one without a signature of who documented it. 08/23/23 noted a new order for Hydroxyzine for itching but the record lacked follow-up as to the results of the new treatment. 08/30/23 noted a new order for Nystatin for thrush and Ativan (antianxiety) every tow hours as needed and 30 minutes before showers, but the record lacked follow-up as to the results of either medication. 09/28/23 noted to have thrush again with another round of nystatin swish and swallow with no follow-up on the results of the treatment.	S5251		

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S5251	Continued From page 13 10/05/23 noted to start Senna and Milk of Magnesia for constipation but the record lacked follow-up as to the results of medications. 10/18/23 noted that R3's "... Head sore is healing..." The record lacked any documentation of the resident having a "head sore" prior to this or any description of the sore, what treatment was done or if it healed. 11/21/23 noted that insulin was on hold until she starts eating but the record lacked documentation of when the resident had stopped eating and that a physician was notified. On 11/28/23 at 01:00 PM Administrative Licensed Nurse stated she expected the nurses to include in their documentation the visit with the resident, what the plan was and then follow through with it. She also acknowledged she expected the documentation to include the time it was documented and/or time of occurrence. Administrative Licensed Nurse B acknowledged the nurse should have followed-up with the results of any medical treatments and new medications. The operator failed to ensure R3's medical record included the time of documentation and the results of action taken related to R3's medical concerns. - Review of R4's medical record revealed he moved into the facility on 10/23/23 with diagnoses of orthostatic hypotension and history of a stroke. R4's "Functional Capacity Screen" (FCS) dated 10/23/23 revealed he was unable to participate in management of his medications and medical	S5251		

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S5251	Continued From page 14 treatments. On 11/27/23 at 11:37 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" were one document (NSA/HCSP). R4's NSA/HCSP dated 10/16/23 revealed the Certified Medication Aides and Licensed Nurses administered R4's medications and medical treatments. Review of R4's medical record included the following documentation in the nursing progress notes from 10/25/23 to 11/27/23: The documentation included seven entries with no time the entry was made, or occurrence happened. 11/01/23 physician faxed requesting medications related to constipation and stomach pain, but the record lacked follow-up if new orders were received or if any action was taken and results of the action. 11/08/23 the staff reported to the nurse the resident had difficulty breathing at night and faxed request to physician for nebulizer. The record lacked follow-up if the resident had any more breathing difficulties, or any action taken related to the resident's concern. The resident's admission nursing assessment dated 10/23/23 identified the resident had poor skin turgor with bruising on both arms, but did not identify the resident had any wounds. On 11/08/23 in the nursing progress notes Licensed Nurse C documented Home Health in facility to change dressing on stage II pressure ulcer (localized injury to the skin and/or underlying	S5251		

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tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Review of the documentation in record lacked evidence the facility licensed nurse assessed the wound, documented measurements, and a description of the wound, treatment and results of the treatment.

On 11/28/23 at 01:00 PM Administrative Licensed Nurse stated she expected the nurses to include in their documentation the visit with the resident, what the plan was and then follow through with it. She also acknowledged she expected the documentation to include the time it was documented and/or time of occurrence. Administrative Licensed Nurse B also acknowledged she would expect the facility nurse to assess R4's wound every couple of days to make sure it was improving and document their findings.

The operator failed to ensure R4's medical record included the time of documentation and the results of action taken related to R4's medical concerns.

- Review of R5's medical record revealed she moved into the facility on 01/29/21 with diagnoses of anxiety disorder and myelodysplastic syndrome (a type of cancer).

Review of R5's Functional Capacity Screen dated -5/17/23 revealed the resident was unable to manage her medications or medical treatments.

On 11/27/23 at 11:37 AM Administrative Licensed

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S5251	Continued From page 16 Nurse B reported the "Negotiated Service Agreement", and the "Health Care Service Plan" were one document (NSA/HCSP). R5's NSA/HCSP dated 05/18/23 revealed the Certified Medication Aides or the Licensed nurse would administer medications and medical treatments. Review of R5's nursing progress notes from 01/11/23 to 11/27/23 included the following nursing documentation: 01/05/23 noted staff found a large boil on the left side of her labia that was warm, red and painful with slight drainage noted. The record lacked follow-up fi physician was notified, any treatment initiated and results of the treatment or if it resolved on it's own. 05/31/23 noted the resident had a large red area on her tailbone and the record lacked documentation of staff continuing to assess the area and if it resolved. 09/27/23 noted the resident perineum area angry in appearance but failed to include follow-up if the Nystatin treatment helped with healing. On 11/28/23 at 01:00 PM Administrative Licensed Nurse stated she expected the nurses to include in their documentation they visit with the resident, what the plan was and then follow through with it. Administrative Licensed Nurse B also acknowledged she would expect the facility nurse to document and follow up on any medical concerns identified. The operator failed to ensure R5's medical record included the results of action taken related to R5's medical concerns.	S5251		

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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 11 residents (R). The sample included three residents and one focused record review. Based on record review and interview the operator failed to ensure staff administered medications according to a Medical Providers written order and professional standards of practice for three (R3, R4, R5) of three sampled residents. Findings included: - Review of R3's medical record revealed she moved into the facility on 07/26/23 with	S5300		

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S5300	Continued From page 18 diagnoses of dementia and diabetes mellitus type II. R3's "Functional Capacity Screen" (FCS) dated 07/24/23 revealed she had impaired cognition and was unable to participate in management of her medications and medical treatments. On 11/27/23 at 11:37 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement", and the "Health Care Service Plan" were one document (NSA/HCSP). R3's NSA/HCSP dated 07/26/23 revealed the facility Certified Medication Aides and Licensed Nurses administered medications and medical treatments and were to anticipate the residents needs. R3's record included a physician's order dated 07/26/23 to administer eight units of Lantus insulin subcutaneous twice a day and hold if blood sugar less than 120. Another order dated 10/10/23 directed staff to administer eight units of Lantus insulin subcutaneous twice a day and hold if blood sugar is less than 180. The resident also had orders for as needed medications: Lorazepam 0.5mg 30 minutes prior to showers and one daily as needed for restlessness; and Hydroxyzine HCL 25 mg three times a day as needed for itching. Review of the October Medication Administration Record (MAR) revealed Certified Medication Aides administered Hydroxyzine 11 times to the resident with no evidence of nurse notification prior to administration, no documentation on the back of the mar as to the time, reason, or results	S5300		

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of the administration of the medication. The October MAR also revealed CMA's administered Lorazepam twice with no evidence of nurse notification prior to administration and no documentation of the results after medication administered.

Review of the November 2023 MAR revealed the resident's blood sugar was 186 at 08:00 AM on 11/25/23 and 246 at 08:00 AM on 11/27/23. The documentation on the MAR had an "H" instead of initials, indicating staff held the resident's insulin.

Review of R3's nursing progress notes dated 11/21/23 at 11:10 AM identified staff fed the resident yogurt and the resident's insulin was on hold until she started eating. There is no prior documentation in the nursing progress notes of a medical provider being notified of the resident not eating and an order to hold her insulin.

Review of the resident's record lacked a physicians order to hold the resident's insulin for any other reason other than a blood sugar less than 180.

On 11/28/23 at 11:00 AM Certified Medication Aide D reported if a CMA administered a PRN medications, they need to initial it was given and on the back document the date and time, reason given per the nurse and the results after it was given. If a medication is held or circled, the CMA is supposed to document on the back of the sheet why it was held or circled.

On 11/28/23 at 1:31 PM Administrative Licensed Nurse B reported she expected the person who gives the medication to initial the Medication

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S5300	Continued From page 20 Administration Record (MAR) when they give it. If the medication is given as needed (PRN) or if something is held the CMA is to document it on the back and are to follow up on the results of any PRN medications. Administrative Licensed Nurse B also looked through R3's chart and acknowledged there was not an order to hold her insulin from a medical provided and did not find anything in the Hospice documentation either. Review of the undated medication guideline/policy information provided on 11/28/23 by Administrative Licensed Nurse B revealed the following: The clinical records shall contain a physicians orders related to the Care Homes management of their medications. Nurse is to be notified of as needed (PRN) medications before they are given. PRN medications are documented with reason and effectiveness of medication and per nurses' instruction. The operator failed to ensure medications the facility was responsible for administering were administered according to a medical care provider's written order and according to professional standards of practice. - Review of R4's medical record revealed he moved into the facility on 10/23/23 with diagnoses of orthostatic hypotension and history of a stroke. R4's "Functional Capacity Screen" (FCS) dated 10/23/23 revealed he was unable to participate in management of his medications and medical treatments.	S5300		

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S5300	Continued From page 21 On 11/27/23 at 11:37 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement", and the "Health Care Service Plan" were one document (NSA/HCSP). R4's NSA/HCSP dated 10/16/23 revealed the Certified Medication Aides and Licensed Nurses administered R4's medications and medical treatments. Review of R4's physician's orders dated 11/22/23 directed staff to administer Cardizem (an antiarrhythmic heart medication) 30 milligrams (mg) every six hours. Review of R4's November 2023 Medication Administration Record (MAR) had no documentation of any qualified staff administering the resident his Cardizem. On 11/27/23 at 03:15 PM Licensed Nurse (LN) C compared the physicians order for Cardizem 30 mg every 6 hours with the MAR which lacked documentation the medication had been administered. LN C went to the medication room to look for the medications cards and did not find them, so he contacted the pharmacy at 03:17 PM to make sure they received the order. When LN C got off the phone with the pharmacy, they reported they filled partial cards for all dosage times and delivered it on 11/25/23. Review of R4's medication container did include the medication cards which when reviewed with Administrative Licensed Nurse B and LN C on 11/27/23 at 03:26 PM revealed staff did not administer R4 his AM, Noon, or PM dosages of	S5300		

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the medication but did administer the bed time dosage on the 25th and the 26th. Administrative Licensed Nurse B stated staff should have administered the medication as ordered and written on the MAR.

The operator failed to ensure qualified staff administered Cardizem according to the physicians' orders.

- Review of R5's medical record revealed she moved into the facility on 01/29/21 with diagnoses of anxiety disorder and myelodysplastic syndrome (a type of cancer).

Review of R5's Functional Capacity Screen dated -5/17/23 revealed the resident was unable to manage her medications or medical treatments.

On 11/27/23 at 11:37 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement", and the "Health Care Service Plan" were one document (NSA/HCSP).

R5's NSA/HCSP dated 05/18/23 revealed the Certified Medication Aides or the Licensed nurse would administer medications and medical treatments.

Review of R5's medical record included a physician's order dated 09/01/22 for Nystatin cream apply to rash under breast twice a day as needed until resolved and an order dated 06/20/22 for Antacid extra strength chewable 1 tablet daily as needed for heartburn.

Review of R5's Medication Administration

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S5300	Continued From page 23 Records / Treatment Administration Record) (MAR/TAR) revealed the following: October 2023 Medication/Treatment Administration Records (MAR/TAR) revealed staff applied the Nystatin cream eight times without documentation for the reason, time, nurse notification or results of treatment. Staff also administered her Antacid once on the 13th with no documentation and administered Acetaminophen two tablets for pain on the 6th with no follow up on results. November 2023 staff administered the antacid on the 5th with no results, administered the Nystatin cream on the 4th and 20th with no documentation on the TAR as to the reason for administration, the time, nurse notification, or results after administration. Review of the undated medication guideline/policy information provided on 11/28/23 by Administrative Licensed Nurse B revealed the following: Nurse is to be notified of as needed (PRN) medications before they are given. PRN medications are documented with reason and effectiveness of medication and per nurses instruction. The operator failed to ensure medications the facility was responsible for administering were administered according to professional standards of practice and facility policy for PRN medications.	S5300		
S5301 SS=E	26-42-205 (d) (3) Facility Administration of Medications (d) (3) A licensed nurse or medication aide shall	S5301		

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S5301	Continued From page 24 perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d)((3)(D) The facility reported a census of 11 residents (R). The sample included 3 residents. Based on record review and interview the Operator failed to ensure the documentation of the administration of medications immediately before or after completion of the task for two (R3, and R4) of 3 sampled Residents. Findings included: - Review of R3's medical record revealed she moved into the facility on 07/26/23 with diagnoses of dementia and diabetes mellitus type II.	S5301		

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S5301	Continued From page 25 R3's "Functional Capacity Screen" (FCS) dated 07/24/23 revealed she had impaired cognition and was unable to participate in management of her medications and medical treatments. On 11/27/23 at 11:37 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement", and the "Health Care Service Plan" were one document (NSA/HCSP). R3's NSA/HCSP dated 07/26/23 revealed the facility Certified Medication Aides and Licensed Nurses administered medications and medical treatments and were to anticipate the residents needs. R3's record included a physician's order dated 07/26/23 to administer eight units of Lantus insulin subcutaneous twice a day and hold if blood sugar less than 120. Another order dated 10/10/23 directed staff to administer eight units of Lantus insulin subcutaneous twice a day and hold if blood sugar is less than 180. Review of the Medication Administration Records (MAR) revealed the following: October 2023 MAR revealed at 08:00 AM on 10/02/23 and 10/03/23 R3's blood sugar was greater than 110 and the MAR lacked initials to incidate the medication was administered. On 10/6/23 at 08:00 PM R3's blood sugar was greater than 120 and staff did not initial ;they administered the insulin. On 10/26/23 at 08:00 PM the resident's blood sugar was 356 and lacked initials that staff administered the insulin. Polyethylene Glycol lacked initials for administration on 10/1/23 and the Nystatin swish	S5301		

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and swallow four time a day for seven day was not initialed as administered for the noon doses on the 28th or 29th.

November 2023 MAR revealed the resident's 08:00 AM blood sugar was greater than 180 on the 7th and the 12th and staff failed to initial administration of the insulin. R3's 08:00 PM blood sugars were greater than 180 on the 14th and the 17th and staff again failed to document administration of the insulin.

On 11/28/23 at 01:31 PM Administrative Licensed Nurse reported staff were supposed to initial on the MAR when they administered medications and for the places were there are not any initials staff probably just forgot to initial they gave it.

Review of the undated medication guideline/policy information provided on 11/28/23 by Administrative Licensed Nurse B revealed staff needed to give medications according to the seven rights which included the right documentation.

The operator failed to ensure qualified staff who administered medications documented then immediately before or following completion of the task.

- Review of R4's medical record revealed he moved into the facility on 10/23/23 with diagnoses of orthostatic hypotension and history of a stroke.

R4's "Functional Capacity Screen" (FCS) dated 10/23/23 revealed he was unable to participate

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S5301	Continued From page 27 in management of his medications and medical treatments. On 11/27/23 at 11:37 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement", and the "Health Care Service Plan" were one document (NSA/HCSP). R4's NSA/HCSP dated 10/16/23 revealed the Certified Medication Aides and Licensed Nurses administered R4's medications and medical treatments. Review of R4's October 2023 Medication Administration Record and Treatment Administration Record (MAR/TAR) revealed staff did not document for administration for R4's Venelex ointment on the 28th and 29th. Staff also failed to documentent administration for the Ipratroptium and Albuteral nebulizer on the 31st. Review of R4's November 2023 Medication Administration Record (MAR) had no documentation of any qualified staff administering the resident his Cardizem. Review of R4's Cardizem medication cards revealed the bedtime dosages had been punched out of the cards for the 25th and 26th, but staff failed to document administration of the medication. Review of the undated medication guideline/policy information provided on 11/28/23 by Administrative Licensed Nurse B revealed staff needed to give medications according to the seven rights which included the right documentation.	S5301		

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S5301	Continued From page 28 On 11/27/23 at 03:24 PM Administrative Licensed Nurse B reported the Certified Medication Aide who administered the Cardizem should have initialed on the MAR that it was administered. The operator failed to ensure qualified staff documented the administration of R4's Cardizem immediately before or after administration.	S5301		