STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175174	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLARK HILLS	2121 MEADOWLARK ROAD MANHATTAN, KS 66502

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00185839. The 2567 was sent electronically on 08/19/24.	F 000		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: The facility identified a census of 121 residents. The sample included three residents. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 1 remained free from misappropriation when Licensed Nurse (LN) G, on 02/11/24 at 06:57 PM, emptied R1's promethazine (medication used to prevent and treat nausea and vomiting) with codeine (narcotic pain medication) liquid into a water bottle and put it in her purse then left the facility with it. This deficient practice placed R1 at risk for missed medications and further misappropriation of medications. Findings included: - R1 admitted to the facility on 01/15/24. R1's Electronic Medical Record (EMR) documented diagnoses of chronic pain, shortness	F 602		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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of breath, and constipation.

The "Admission Minimum Data Set (MDS)" dated 01/23/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment.

The "Quarterly MDS" dated 07/24/24, documented R1 had a BIMS score of 11 which indicated cognitive impairment.

The "Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA)," dated 01/25/24, documented R1 communicated her needs with clear speech and had a BIMS score of 11.

R1's "Care Plan," dated 01/15/24, documented R1 had an activity of daily living (ADL) self-care performance deficit.

R1's EMR documented an order with a start date of 01/15/24, for promethazine-codeine five milliliters (ml) every four hours as needed (PRN) for cough.

A review of R1's "Medication Administration Record (MAR)" for 01/15/24 to 03/31/24, revealed R1 received promethazine-codeine five mL on 03/01/24.

LN J's "Witness Statement" dated 02/13/24, documented on 02/11/24, she and LN G performed a narcotic count. After the count, LN G asked LN J for the keys to the medication room so she could get into the petty cash box. LN J stated she handed LN G the keys and after a short while, LN G brought the keys back to her.

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LN H's "Witness Statement" dated 02/15/24 documented that on 02/12/24 during the narcotic count, he checked R1's promethazine-codeine syrup and it did not match the count sheet. He stated the count noted 120 mL of medication remained, however, the liquid was far below the 120 mL mark on the bottle. LN H stated he noted the bottle's broken seal and the below-indicated level on the bottle during the narcotic count. He stated he had not administered any of the medication to R1 and R1 did not report having a cough.

The facility's investigation, dated 02/16/24, documented on 02/12/24 at approximately 03:30 PM during shift change narcotic count, LN H noted a broken seal on R1's promethazine-codeine bottle and the volume of the bottle did not match the count sheet. The documentation did not support that staff gave a dose to R1. LN I denied giving any doses and did not notice the discrepancy when she started her shift that morning. Staff notified Administrative Staff A and Administrative Nurse D of the discrepancy and they started an investigation. The facility reached out to staff for witness statements to determine if R1 received a dose and the nurse failed to document it. The facility initiated a review of the camera footage in the medication room. The camera footage revealed on 02/11/24 at 06:57 PM, LN G counted with LN J. LN J received the keys during the count, and after both nurses completed the count, they exited the medication room and returned to the household. LN J stated LN G asked her for the keys back to get into the medication room to get petty cash out to pay for pizza LN G purchased for the residents. The camera footage revealed

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on 02/11/24 at 07:12 PM, LN G entered the medication room opened the narcotic cabinet, and removed two medication bottles. She emptied a water bottle and poured the contents of both medication bottles into the water bottle then filled the medication bottles up with water from the sink. LN G placed the medication bottles back into the narcotic cabinet exited the medication room and then into the household. She placed the water bottle filled with the medication liquid in her purse then returned the keys to LN J. LN G finished up her work then grabbed her purse to leave at 07:40 PM. On 02/12/24 at 04:30 PM, Administrative Nurse D relieved LN G of duty and brought her into the office for questioning. LN G gave her a statement and denied giving R1 any doses of her promethazine-codeine liquid and stated the seals easily broke when staff handled the bottles during the count. After Administrative Nurse D obtained LN G's statement, she showed LN G the camera footage. LN G immediately stated she knew, and said she was sick. The facility terminated LN G and escorted her out of the building. R1 moved into the facility on 01/15/24 with two bottles of promethazine-codeine liquid, one had 120 mL and the other had five mL. Due to the expiration dates, the facility planned to destroy both bottles with the February narcotic destruction. The facility ordered a third bottle of promethazine-codeine liquid upon R1's admission which had 120 mL. Both bottles LN G emptied were red and made any liquid inside appear red which made it impossible for the nurses to recognize the bottles had water instead of medication.

On 08/06/24 at 12:08 PM, R1 sat in a chair in her room and ate lunch independently.

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On 08/06/24 at 11:14 AM, Administrative Nurse D stated the facility did not complete abuse, neglect, and exploitation education after the incident. She stated the facility completed controlled substance education and understood the incident would be considered misappropriation of property but felt that it was covered under the Controlled Substances Act education.

On 08/06/24 at 12:11 PM, LN H stated he prevented misappropriation of medications by following medication administration rights and completing narcotic count at change of shift. He stated the off-going nurse looked at the narcotic count sheets while the on-coming nurse counted the narcotics for comparison with the sheet. LN H stated he found the discrepancy with R1's promethazine-codeine liquid and reported it to Administrative Nurse E immediately for investigation.

On 08/06/24 at 12:17 PM, Administrative Nurse E stated LN H reported R1's promethazine-codeine syrup discrepancy to her and she reported it immediately to Administrative Nurse D. She stated she did a narcotic count sheet and medication audit including assessing any medication bottles and checking the narcotic sheets.

On 08/06/24 at 01:01 PM, Administrative Nurse D stated LN H noticed R1's promethazine-codeine syrup discrepancy and notified Administrative Nurse E who notified her. She stated the facility obtained statements from the nurses and started camera footage review. Administrative Nurse D stated the facility interviewed R1 who stated she had not received any promethazine-codeine

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syrup. She stated during the camera footage review, she observed LN G in the medication room with a water bottle that she emptied. Administrative Nurse D stated LN G took R1's promethazine-codeine bottles out of the lock box and poured them into the emptied water bottle then filled the medication bottles up with water and put them back in the lock box. She stated LN G exited the medication room with the water bottle and put it into her purse then left the facility with the purse. Administrative Nurse D stated after she saw LN G take the medications on the camera footage, she pulled LN G off her shift and brought her into her office to write a statement. She stated she asked LN G to walk her through the events and then showed her the footage. Administrative Nurse D stated she fired LN G and staff escorted her out of the facility. She stated she expected staff to make sure they counted the narcotic medications correctly and expected staff not to turn over keys after receiving them for their shift. Administrative Nurse D stated she expected staff to not take medications and to report any discrepancies immediately.

On 08/06/24 at 01:16 PM, Administrative Staff A stated she expected if nurses noticed any discrepancies, they would notify the charge nurse immediately. She stated she expected staff to know that it is bad to take things that do not belong to them and that misappropriation would not happen.

The facility's "Preventing Resident Abuse, Neglect, and Misappropriation of Property Policy," revised in March 2017, directed each resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy defined misappropriation

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F 602	Continued From page 6 of resident property as the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without their consent. The facility failed to ensure R1 remained free from misappropriation of medication. This deficient practice placed R1 at risk for missed medications and further misappropriation of medications.	F 602		