Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N001007	A. BUILDING: _____ B. WING _____	10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARROWOOD LANE	615 E FRANKLIN HUMBOLDT, KS 66748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named Residential Living facility conducted on 10/29,30/2018.	S 000		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 23 residents. The sample included 3 residents and 1 focused review. Based on interview and record review the operator failed to ensure designated staff administered 2 (#101 and #102) of 3 residents medications in accordance with medical care provider's written order and professional standards of practice.	S3200		

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

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S3200	Continued From page 1 Findings included: - Review of resident #101's medical record revealed he/she admitted to the facility on 9/17/18 with diagnosis of anxiety, hypertension, and psychosis. Review of the functional capacity screen dated 9/17/18 revealed the resident could not manage his/her own medications and treatments. Review of the negotiated service agreement dated 9/17/18 revealed staff would provide physician ordered medications. Review of the physicians orders from hospital return dated 10/5/18 revealed an order for Cymbalta (an antidepressant) 30 mg twice a day. The physicians orders did not include any continuation of as needed medications. Review of the October 2018 medication administration record (MAR) contained the correct order but only had verification for administration of the medication 1 time per day instead of twice. The MAR also included the following as needed medications: artificial tears 1 drop both eyes every 8 hours as needed; Gold bond medicated powder apply as needed; loperamide 2 mg 4 times daily as needed for loose stools; Tylenol 500 mg 1 tablet every 8 hours as needed; Mirilax 17 grams every 24 hours as needed for constipation; Ventolin inhaler 2 puffs every 8 hours as needed for chronic obstructive pulmonary disease. During an interview on 10/29/18 at 1:35 PM licensed nursing staff A confirmed the Cymbalta was to be administered twice a day and was only	S3200		

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S3200	Continued From page 2	S3200		

on the MAR for verification of administration once a day. Staff A also confirmed the as needed medications were not on the hospital return physicians orders and should have been clarified before being added to the MAR.

The operator failed to ensure licensed nursing staff verified accuracy of medication administration record with physicians orders.

- Review of resident # 102's medical record revealed the resident admitted to the facility on 7/2/18 with diagnosis of depression and anxiety.

Review of the functional capacity screen dated 7/2/18 revealed the resident could not manage his/her own medications.

Review of the negotiated service agreement dated 7/2/18 revealed staff would provide physician ordered medications.

Review of the original admission orders dated 7/2/18 included an order for sertraline 50 mg 2 tabs daily. (100 mg)

Review of the physician recapulation sheet dated 7/31/18 included an order for sertraline (an antidepressant) 50 mg. daily.

Review of the October 2018 medication administration record directed staff to give sertraline 100 mg tablet daily.

During an interview on 10/30/18 at 9:30 AM licensed nursing staff A reported he/she had reviewed the resident's record yesterday and caught the discrepancy related to the sertraline. Staff A stated the resident had been getting 100 mg which is what it is supposed to be. There had

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S3200	Continued From page 3 been no orders to decrease it to 1 50 mg tablet. The operator failed to ensure licensed nursing staff verified accuracy of recapulation orders with current physician orders.	S3200		