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CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility and complaint investigations #138749, #142370 and #146897 conducted on 11/06/19, 11/07/19 and 11/13/19.	S 000		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (a) The facility reported a census of 21 residents. The sample included 3 residents and 3 closed record focused reviews. Based on observation, interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for 3 of 3 sampled residents (#117, #312 and #463) regarding fall risks and self-administration of certain medications. Findings included: - Record review for resident #117 revealed an admission date of 5/21/18 with diagnoses of	S3155		

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

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dementia with behavioral disturbances and paranoid delusions, generalized anxiety disorder, depression, hypertension, diabetes mellitus and history of urinary tract infections.

The annual functional capacity screen dated 5/16/19 indicated the resident had short and long-term memory impairment, impaired memory recall and decision making. She required physical assistance with bathing and supervision with dressing and eating. She had wandering and socially inappropriate behaviors. The significant change FCS dated 11/01/19 indicated the resident needed physical assistance with all activities of daily living (ADLs) - bathing, dressing, toileting, transfers, walk/mobility and eating. She used a walker and a wheelchair for assistive devices and was at risk for falls/unsteadiness.

The negotiated service agreement/health service plan (NSA/HSP) dated 5/16/19 and with 4 amendments until revised on 11/01/19 directed staff the resident required some physical assistance in getting in/out of the shower and assistance with lower extremities. She required assistance from staff on what to wear and staff should get the clothes out of the closet for her. She could transfer independently and use the bathroom independently. She had a steady gait and ambulated independently with occasional use of a personal walker. The amendments were for the start and stop of therapy services (6/24/19 until 7/02/19) with no amendments related to the resident falling.

Review of the nursing notes (NN) and compared to facility incident reports revealed the resident had the following fall history:
On 8/21/19 at 4:00 AM the resident's bathroom call light was activated and when staff arrived

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staff found the resident sitting on the floor next to the toilet. The resident stated she thought she had gotten a little dizzy when she went to sit down. Blood pressure at that time was 159/77 with a pulse of 62, temperature of 97.2 degrees Fahrenheit and oxygen saturation of 90%. Follow up vital signs reflected Blood pressures taken once a shift for 2 days which ranged 111/64 to 167/87 and no evaluation for orthostatic hypotension as possible cause for the dizziness.

Review of the incident report dated 8/21/19 revealed no additional information, no evaluation of causal factors or interventions developed to reduce the risk of further falls.

NN - On 9/25/19 at 12:56 PM staff recorded finding the resident on the floor and the resident stated her knees went out and she lowered herself to the floor. The next entry 9/25/19 at 9:52 PM resident complaint of knee pain - no nurse assessment recorded. The notes indicated staff monitored the resident for 3 days post fall and noted intermittent knee pain with resident refusal for pain medication. The notes had no evaluation into causal factors for the knees giving out or interventions to reduce the risk for further falls.

Review of the incident report dated 9/25/19 revealed no additional information related to a fall causal factor or interventions developed to reduce the risk for further falls.

The NN reflected the resident fell on 10/22/19 and the medical care provider ordered lab testing, medication adjustment and physical/occupational therapy to address the knee weakness.

NN - dated 10/23/19 at 12:24 PM ... resident has

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increased weakness and required rest periods while ambulating. Resident is not able to walk the distance to her room and began utilizing a wheelchair at this time... The notes failed to indicate if fall prevention would include staff assistance while ambulating.

NN - On 10/24/19 at 7:52 PM written by certified staff G indicated the resident fell while exiting the beauty shop. She was using her walker. She fell, hitting the frame of the door with her back. The beautician asked certified staff member G for assistance to help the resident walk and she fell while the staff member was walking toward her. The notes did not include an evaluation of the resident's fall and whether staff were providing the assistance the resident needed.

On 11/07/19 at 9:45 AM licensed nurse B reported she could not find an incident report for the 10/24/19 fall. She confirmed neither the nursing notes or incident reports included an evaluation into causal factors or development of interventions to reduce the resident's fall risk.

Observation on 11/06/19 at 12:44 PM with certified staff C and D revealed the resident did not want to get out of bed to use the rest room. Staff checked the resident for incontinence and repositioned her onto her right side.

Interview on 11/06/19 at 12:40 PM with certified staff C revealed the resident needed staff assistance of 1 to get up and walk to the bathroom and otherwise used the wheelchair to get around.

The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs

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for this resident with a known fall risk, history of falls and declining ADL abilities.

- Record review for resident #312 revealed an admission date of 4/17/15 with diagnoses of atrial fibrillation, hypertension, peripheral vascular disease, osteoarthritis and weakness.

The significant change functional capacity screen (FCS) dated 10/24/19 indicated the resident had intact cognition, needed physical assistance with all activities of daily living (ADLs) except eating, used a walker and a wheelchair. She was at risk for falls/unsteadiness with impaired vision and hearing.

The negotiated service agreement/health service plan (NSA/HSP) dated 10/24/19 directed staff to provide assistance with all activities of daily living (ADLs) - bathing, dressing, toileting (use of bedside commode), transfers between surfaces and mobility. The section for transfers was marked with a check mark for self, staff and outside provider. The resident needed physical assistance although she may be involved in the process of transferring, she needed help such as guided maneuvering of the limbs, weight bearing, assisting to stand or balance/stability assistance. The comments - She got short of breath and tired easily so required assist of 1 staff to stand and pivot. She should call for assistance before transfer for safety. The box to identify the resident as a high fall risk was not marked and did not include any other fall reduction interventions. Comments - she may require oxygen for comfort when in the wheelchair.

Observation on 11/06/19 at 12:35 PM revealed certified staff C and D provided repositioning for the resident while in bed. The resident used the

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attached bed assist device to turn side to side. The staff used the bed pad to physically move the resident up in the bed.

Interview on 11/06/19 at 12:35 PM with certified staff C revealed the resident does get up to the bedside commode most days and required assistance of 1 staff to transfer from the bed to the wheelchair. She said the resident wanted to remain in bed most of the time for comfort.

Interview on 11/06/19 at 2:00 PM with licensed nurse B confirmed the FCS identified the resident as a fall risk but the NSA/HSP did not address this risk.

The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for this resident with a known fall risk.

- Record review for resident #463 revealed an admission date of 1/16/19 with diagnoses of congestive heart failure, atrial fibrillation with rapid ventricular response, dyspnea, chronic obstructive pulmonary disease, asthma and osteoarthritis.

The admission functional capacity screening dated 1/18/19 identified the resident with intact cognition and needed physical assistance to manage medications. The self-administration assessment dated 1/18/19 indicated the resident was safe to self-administer over the counter Tylenol.

The negotiated service agreement/health service plan (NSA/HSP) dated 1/18/19 indicated the resident needed physically assistance with medications when they are due. Under the

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S3155	Continued From page 6 comments were directions for self-administration of Tylenol and all other medications are given by facility staff. The current signed medical care provider orders included the following medications for the resident to keep at the bedside: extra strength acetaminophen (Tylenol) 500 milligram (mg) 1 or 2 tabs every 6 hours PRN (as needed) PRN for pain, benzocaine 1 application by mouth as needed for gum pain, Tums (antacid) 750 mg 1 PRN 3 times a day Observation on 11/06/19 at10:53 AM revealed the following over the counter medications on the table next to her chair or on the desk: Tylenol arthritis strength, cough drops and antacid tablets. The resident said she takes the medications when she needs them. Interview on 11/06/19 at 2:46 PM licensed nurse B confirmed the resident was assessed to and planned to self-administer over the counter Tylenol. She was not aware the resident had other medications in her room and would re-evaluate the resident for the medications. She confirmed the NSA/HSP only listed the 1 medication as a self-administer keep at bedside. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for this resident regarding self-administration of certain medications.	S3155		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications	S3200		

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S3200	Continued From page 7 (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 21 residents. The facility identified 17 residents with facility managed medications. The sample included 3 residents. Based on record review and interview the operator failed to ensure licensed nurses and certified medication aides administered facility managed medications in accordance with a medical care provider's written order and professional standards of practice for 2 of 3 sampled residents #312 and #463 regarding transcription of orders Findings included: - On 11/06/19 licensed nurse B provided a resident roster which identified resident #312	S3200		

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S3200	Continued From page 8 received facility managed medications. The significant change functional capacity screen dated 10/24/19 identified the resident as unable to manage her own medications. The negotiated service agreement/health service plan (NSA/HSP) dated 10/24/19 directed certified or licensed staff to administer all the resident's medications. Comparison of the 10/24/19 signed recapitulation of the medical care provider's written orders and all subsequent orders with the November 2019 medication administration record (MAR) revealed the following medical care provider's orders did not appear on the November 2019 MAR: acetaminophen 650 milligrams (mg) suppository - insert 1 rectally every 4 hours PRN (as needed) pain/fever ordered 10/24/19 bisacodyl 10 mg suppository - insert 1 rectally PRN constipation ordered 10/24/19 bio freeze - apply to left knee/hip PRN ordered 1/23/18 Interview on 11/06/19 at 1:53 PM with licensed nurse B confirmed the discrepancies with the written orders and the November 2019 MAR. She reported the orders were not transcribed to the November 2019 MAR. The administrator/operator failed to ensure licensed nurses and certified medication aides administered facility managed medications in accordance with a medical care provider's written order and professional standards of practice for this resident regarding transcription of orders. - On 11/06/19 licensed nurse B provided a resident roster which identified resident #463	S3200		

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S3200	Continued From page 9	S3200		

received facility managed medications with the exception of some over the counter PRN (as needed) medications which the resident self-administered and kept at the bedside.

The admission functional capacity screening dated 1/18/19 indicated the resident had intact cognition and needed physical assistance with medication management.

The negotiated service agreement/health service plan (NSA/HSP) dated 1/18/19 revealed the resident would self-administer Tylenol and the facility staff would administer all other medications.

Review of the medical care provider's (MCP) written orders revealed on 8/16/19 the MCP ordered Ensure clear 1 box with meals 3 times a day to treat weight loss associated with nausea. On 10/23/19 licensed nurse B received orders from the MCP to discontinue the Ensure clear per the resident's request.

Review of the November 2019 medication administration record (MAR) revealed licensed nurse B failed to transcribe the order to discontinue the Ensure clear and staff had initialed and circled their initials 3 times a day on 10/24/19 thru 11/06/19 (13 days)

Interview on 11/06/19 at 2:46 PM with licensed nurse B confirmed the circled initials indicated staff did not administer the prescribed medication. She reported obtaining the order to discontinue the Ensure clear on 10/23/19 but did not discontinue it on the MAR.

The administrator/operator failed to ensure licensed nurses and certified medication aides

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S3200	Continued From page 10 administered facility managed medications in accordance with a medical care provider's written order and professional standards of practice for this resident regarding transcription of orders.	S3200		
S3202 SS=E	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) (4) The facility reported a census of 21 residents with 3 who the facility managed blood sugar testing and insulin pen administration. Based on interview and record review the operator failed to ensure a licensed nurse oriented and instructed certified medication aides (CMA) C, F, G, H and J in the performance of blood sugar testing, dialing a dose of insulin by insulin pen for the resident to self-inject and further failed to document a demonstration of the staff's competency signed by the nurse and the CMA in each person's personnel record. Findings included: - On 11/0/19 licensed nurse B reported certified medication aides (CMAs) were delegated to perform blood sugar testing and dose dialing of the insulin pens.	S3202		

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S3202	Continued From page 11 Review of the personnel file for CMA C on 11/07/19 revealed she began employment on 12/17/18. The record lacked documentation of additional training to allow this CMA to perform blood sugar testing or dose dialing of insulin pens. Interview with CMA C on 11/06/19 at 9:42 AM revealed she performed blood sugar testing and dialed the dose of the insulin pens for residents to self-inject based on the medical care provider's written orders. Interview on 11/07/19 at 11:43 AM with licensed nurse/operator A revealed the facility currently had 8 CMAs who were expected to perform blood sugar testing and dialing of insulin pens. She confirmed the personnel records for CMA F, G, H and J lacked documentation by a licensed nurse for instructing and verification of competency to allow these CMAs to perform blood sugar testing and dialing of insulin pens. The operator failed to ensure a licensed nurse oriented and instructed certified medication aides (CMA) C, F, G, H and J in the performance of blood sugar testing, dialing a dose of insulin by insulin pen for the resident to self-inject and further failed to document a demonstration of the staff's competency signed by the nurse and the CMA in each person's personnel record.	S3202		
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	S3215		

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S3215	Continued From page 12 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 ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (h) (4) The facility reported a census of 22 residents. The facility identified 17 residents with facility managed medications 3 of which required insulin injections. Based on observation, record review and interview the operator failed to ensure licensed nurses and certified medication aides	S3215		

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S3215	Continued From page 13 could not administer medications beyond the medication manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated insulin pens once opened for 3 of 3 residents whose insulin the facility managed (#117, #572 and #580). The operator further failed to ensure a licensed nurse could not administer medication beyond the manufacturer's or pharmacy provider's recommended date of expiration for an opened bottle of tuberculosis testing solution. Findings included: - On 11/06/19 licensed nurse B provided the resident roster which identified 17 residents received facility managed medications and 3 of those residents received insulin managed by the facility (#117, #572 and #580). Observation on 11/06/19 at 9:42 AM revealed certified medication aide (CMA) C opened the only medication cart and in the top drawer were diabetic supplies and insulin pens managed by the facility. Resident #117 had an open/used Novolog insulin pen with no opened date. Resident #572 had an open/used Lantus insulin pen and an open/used Humalog insulin pen with neither having a date when staff began using them. Resident #580 had a Levemir insulin pen which had a label on the cap of opened 9/18/19 and discard 10/18/19. The insulin pen did not appear to be used and CMA C said it was probably the cap from the previous insulin pen. Interview on 11/06/19 at 9:42 AM with CMA C revealed she performs blood sugar testing for residents, and she dialed the dose on the insulin pens per the medical care provider's written orders for the resident to self-inject. She said the	S3215		

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CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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
S3215	Continued From page 14	S3215		

pens were supposed to be dated when staff began using them. She reported the pens were only good for 29-30 days.

Interview on 11/06/19 at 9:55 AM with licensed nurse B confirmed the CMAs dialed the dose of the insulin for the residents and were expected to date the insulin with the first use to ensure they pen was not used after 28 days.

The Novolog Flex pen manufacture recommended to store opened insulin at room temperature for up to 28 days and discard even if insulin remained.

Humalog Kwik pen manufacture recommended to store opened insulin at room temperature for up to 28 days and discard even if insulin remained.

The Levemir FlexTouch manufacture recommended to store opened insulin at room temperature for up to 42 days and discard even if insulin remained.

The Lantus Solostar pen manufacture recommended to store opened pens at room temperature and after 28 days the opened Lantus pen should be thrown away-even if it still has insulin in it.

The operator failed to ensure licensed nurses and certified medication aides could not administer medications beyond the medication manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated insulin pens once opened.

- On 11/06/19 at 9:42 AM certified medication aide (CMA) C opened the medication room refrigerator. Observation revealed an opened

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	C 11/13/2019

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CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

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S3215	Continued From page 15 and used bottle of tubersol (tuberculosis) testing solution without a date on the bottle. The box flap read opened 8/26/19 and the pharmacy dispensing label indicated a fill date of 8/14/19. Interview on 11/06/19 at 9:55 AM with licensed nurse B confirmed the tubersol testing solution should only be used for 30 days after the bottle was opened/used. The FDA (Federal Drug Administration) manufacture of the tubersol directed the tubersol testing solution would expire 30 days after the date of opening. The operator failed to ensure a licensed nurse could not administer medication beyond the manufacturer's or pharmacy provider's recommended date of expiration for an opened bottle of tuberculosis testing solution.	S3215		
S3265 SS=F	26-41-104 (a) Disaster and Emergency Preparedness (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104 (a) The facility reported a census of 21 residents with 12 having impaired cognitive function and 6 who	S3265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	C 11/13/2019

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S3265	Continued From page 16	S3265		

needed physical assistance to toilet. Based on record review and interview the administrator/operator failed to conduct an annual emergency evacuation drill with the least amount of staff on duty to ensure the provision of a sufficient number of staff members needed to take residents who would require assistance in an emergency or disaster to a secure location.

Findings included:

- On 11/06/19 licensed nurse B provided the resident roster which identified 12 of 22 residents with cognitive impairment, 6 residents who needed physical assistance to toilet and 3 identified needing a 2 person assist to transfer between surfaces (bed/chair). Later on, 11/06/19 at 4:45 PM interviews with certified staff revealed the 3 residents could be transferred between surfaces with 1 staff member.

During the entrance conference on 11/06/19 at 4:35 PM licensed nurse B reported staffing the residential health care with 1 staff member during the overnight hours.

On 11/07/19 at 11:35 AM administrator/operator A reported she took over the role as administrator in May of 2019 and she had not conducted an evacuation drill. She reported no knowledge of when the last evacuation drill was conducted, and she could not locate any documentation of such. She reported speaking with the maintenance staff, and he did not have any record of an annual drill.

Interview on 11/07/19 at 11:50 AM with certified staff E revealed she participated in an evacuation sometime around the end of February 2019 of all the residents to the parking lot with 4 staff and

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S3265	Continued From page 17 thought it took somewhere between 5-7 minutes. The administrator/operator failed to conduct an annual emergency evacuation drill with the least amount of staff on duty to ensure the provision of a sufficient number of staff members needed to take residents who would require assistance in an emergency or disaster to a secure location.	S3265		