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 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 conducted on 8/7/18 and 8/8/18.	S 000		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	S3028		

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

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S3028	Continued From page 1 KAR 26-41-101 (f)(3) (A), (B), (C) The facility reported a census of 32 residents. The sample included 3 residents and 1 resident for a focused review regarding safety. Based on record review and interview the administrator/operator failed to start an investigation following notification of an elopement (when a resident becomes absent from the facility without staff's knowledge), failed to ensure immediate interventions were put in place to prevent further elopement for 1 of 4 residents sampled (#607) when he/she eloped from the facility on 2/19/18. The administrator/operator failed to submit a thorough investigation within five working days to the State Agency. Findings included: - Review of the record for resident #607 revealed an admission date of 12/8/17. He/she had diagnoses of traumatic subdural (part of the brain) hemorrhage without loss of consciousness, hypertension and major depressive disorder. The admission functional capacity screen dated 12/8/17 short term memory deficit, impaired memory/recall and decision making. He/she required physical assistance with bathing, dressing, toileting, transfers, walking/mobility and had a history of falling. The elopement risk assessment dated 12/8/17 identified the resident as a low risk for elopement. A follow up elopement risk assessment dated 2/19/18 was initiated but not completed. The admission negotiated service agreement (NSA)/health service plan (HSP) dated 12/8/17	S3028		

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S3028	Continued From page 2	S3028		

indicated the facility staff would provide the resident moderate physical assistance with bathing, dressing and toileting. Staff should provide the resident with physical assistance at times with standing from chairs, he/she had balance deficits when making direction changes which required staff assist with directions about the facility as needed. The record included an amended NSA dated 2/22/18 regarding discontinue of physical therapy and an amended NSA on 4/28/18 with a change in nurse responsible for the HSP. The record lacked any review/revision of the NSA/HSP to address the resident's elopement on 2/19/18 and further risk for elopement.

Review of the resident progress notes between 12/8/17 and 5/1/18 (time of discharge from the facility) revealed on 2/19/18 at 10:00 AM licensed nurse G recorded, the resident walked out the exit door and was off the grounds of the facility. Staff last saw the resident in the wellness room on the NuStep exercise bike about 9:15 AM. Staff received a call from the convenient store down the street with the report of an elderly person walking. The convenient store staff described the elderly person who fit the description of resident #607. Staff informed another CMA and they went towards the convenient store to look for the resident. Another CMA was called by then and a search was performed in the building and on the grounds by staff, LPN and Administrator. Staff was alerted to a person in a red SUV picking up the elderly person and the administrator drove to find the SUV and go to the police station. Licensed nurse G called and reported incident to the police station with information given regarding the administrator driving that way to see if the elderly person was resident #607. The administrator found the SUV parked on the road

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waiting for the police and he/she got the resident and returned him/her safely to the facility. Informed risk agreement was discussed and signed with spouse with plan for him/her to keep a closer watch on resident #607 until lab results were received and noted to rule out illness. If he/she could not watch the resident closely, he/she would alert staff and staff would do 15-minute checks on resident #607 until the spouse felt better. Staff will continue to watch and check on the resident hourly and try to occupy him/her with activities if the spouse could not watch resident #607. No noted injury, his/her hands were cold due to being outside. The temperature was about 64 degrees outside. He/she wore a long sleeve shirt on and sweat pants.

The facility provided documentation of staff verifying the resident's whereabouts beginning 2/19/18 at 10:15 AM through 3/2/18 at 11:00 PM. The sheet had a breakdown by every 15 minutes per 24 hours. Staff made entries at the start of the hour in some cases and then drew a line through the rest of the hour. Unknown what the line meant, and no staff initials were included to show who verified the resident's whereabouts. Some of the 15 minutes time tables were blank.

Observation on 8/8/18 at 12:00 PM revealed an exit door directly across the wellness room from the Nustep exercise bike where the resident was last seen by staff. The door opened freely from the inside and outside. When the door was open a door bell sound (ding - dong) sounded 1 time. The surveyor opened the door 3 times without any staff coming to verify who entered or exited from the door.

Interview on 8/8/18 at 11:30 AM licensed nurse E

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reported contacting administrator/operator F by phone who said he/she did not complete an investigation for the elopement of resident #607 on 2/19/18.

Interview on 8/8/18 at 12:35 PM certified medication aide H reported the resident usually was with his/her spouse but on occasion had been outside on his/her own out back by the cottages where he/she used to live. CMA H reported all the exit doors except for the front door have a doorbell sound when the door is opened. He/she said during the day time when people are coming and going staff does not respond to the doorbell sounds but in the evening and overnight staff would go to the door and check who was coming or going. He/she said at about 9:00 PM at night staff set an alarm to sound on the exit doors which is different than the doorbell sound. He/she indicated this system was the same as prior to the elopement.

Interview on 8/8/18 at 1:00 PM licensed nurse E reviewed the resident's record and confirmed no reassessment of his/her elopement risks was completed and the NSA/HSP lacked revision to include the risk for further elopement with interventions for staff to prevent further elopements. He/she confirmed the documentation for visual checks of the resident's whereabouts ended 3/2/18.

Review of the facility's policy titled door monitor policy for elopement dated 5/07 revealed all outside doors are equipped with monitor buzzer that goes off when opened from the inside or outside with the exception of the front door, during normal business hours. The policy lacked directions of what staff should do if the door buzzer sounded. It included all employees shall

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S3028	Continued From page 5 be in-serviced on safety of resident and policies covering door monitor during orientation and annually. Review of the elopement policy dated 5/07 included prior to admission an assessment for elopement, history of wander, impaired decision making and changes in cognition and mobility would be completed. On-going resident assessment of monthly summaries, daily observations with documentation of change in the resident's condition, assessment of level of assistance needed as well as wandering. The policy included the same information about the exit door monitoring system and staff training. The administrator/operator failed to start an investigation following notification of an elopement (when a resident becomes absent from the facility without staff's knowledge), failed to ensure immediate interventions were put in place to prevent further elopement for this resident when he/she eloped from the facility on 2/19/18. The administrator/operator failed to submit a thorough investigation within five working days to the State Agency.	S3028		
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	S3211		

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S3211	Continued From page 6 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 32 residents. Based on observation and interview for all residents receiving facility management of medications, the administrator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on each over-the-counter (OTC) medication package or container in the only medication room and only medication cart. This deficient practice affected residents (#604, #605 and #606) and residents who may have received OTCs from bottles labeled floor stock. Findings included: - The facility roster identified 26 residents who received facility managed medications. On 8/7/18 at 12:45 PM licensed nurse E opened the only medication cart for review. Observation revealed in the second drawer were multiple bottles/containers of medications for residents in a large plastic zip-lock bag. Resident #604 had 4 over the counter medications (OTC) which were not labeled with his/her full name. Within the bag was an OTC labeled with resident #605's full name. Another large plastic bag for resident #606 had an OTC without the resident's full name on the bottle.	S3211		

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S3211	Continued From page 7 In the bottom drawer of the medication cart was multiple OTC medications labeled as floor stock and not for specific residents with physician orders to receive as follows: Ultra Tuss cough syrup x 2, acetaminophen 500 milligram (mg), Advil 200 mg, loperamide 2 mg and polyethylene glycol. The bottom drawer of the medication cart also included the following OTC medications without any labeling: Vaseline 13-ounce jar, vitamin A & D cream, tussin cough syrup 8 ounce bottle, Bayer aspirin 325 mg, milk of magnesia, advanced antacid regular strength, Imodium 2 mg, natural care gel and a large bag (200 drops) of cough drops. The top drawer of the medication cart had unlabeled partially used tube of hydrocortisone cream 2.5% and a used tube of mupirocin ointment 2 %. Interview on 8/7/18 at 12:45 PM with licensed nurse E revealed he/she usually wrote the resident's name on the OTC medications. The facility's policy for over the counter medications directed all OTC medications should remain in the original container and labeled with the resident's name. The administrator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on each over-the-counter (OTC) medication package or container in the only medication room and only medication cart.	S3211		

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S3248	Continued From page 8	S3248		
S3248 SS=E	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102 (d)(2)(3) The facility reported a census of 32 residents. Based on interview and record review the facility failed to have evidence of criminal background verification for certified medication aide (CMA) A and certified nursing assistant (CNA) D. The	S3248		

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facility also failed to have evidence of nurse aide registry verification for 4 of 4 CNA/CMAs hired since last resurvey (CNA B and D, CMA A and C).

Findings included:

- Personnel record review on 8/7/18 revealed the facility failed to have evidence of a criminal background check for certified medication aide (CMA) A who began employment on 6/12/18 and certified nursing assistant (CNA) D who began employment on 5/30/18.

The facility failed to have evidence of verifying the registry status for CMA A who began employment on 6/12/18. The personnel file included an undated nurse aide registry verification which did not indicate the registry was checked before CMA A provided care to residents. The file for CNA B who began employment on 1/18/18 included an undated nurse aide registry verification which did not indicate the registry was checked before CNA B provided care to residents. The file for CMA C who began employment on 6/5/17 included an undated nurse aide registry verification which did not indicate the registry was checked before CMA C provided care to residents. The file for CNA D who began employment on 5/30/18 included an undated nurse aide registry verification which did not indicate the registry was checked before CNA D provided care to residents.

Interview on 8/7/18 at 4:40 PM with administrator F revealed he/she could not get the website to accept the request for the criminal background so he/she submitted a paper request. He/she confirmed a lack of payment record to show the request was submitted. He/she confirmed the registry verification page for the 4 CMA/CNAs listed above lacked a date of the verification to

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S3248	Continued From page 10 indicate it was checked prior to provision of care to residents. The facility failed to have evidence of criminal background verification for certified medication aides (CMAs) and certified nursing assistants (CNAs). The facility also failed to have evidence of nurse aide registry verification prior to the provision of care to residents by 4 CNA/CMAs hired since last resurvey (CNA B and D, CMA A and C).	S3248		