STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023021	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEUVANT HOUSE OF LAWRENCE EAST	1216 B BILTMORE DR LAWRENCE, KS 66049

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaint 92759 at the above named residential health care facility conducted on 5-23-16, 5-24-16 and 5-25-16.	S 000		
S 135 SS=D	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment. This STANDARD is not met as evidenced by: KAR 26-39-103(h)(1)(C) The facility reported a census of 8 residents. The sample included 3 residents and one closed	S 135		

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

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S 135	Continued From page 1	S 135		

record review. For 1 (#115) of 3 residents, the operator failed to ensure that designated facility staff consulted with the resident's physician and notified the resident's legal representative upon occurrence of a need to alter treatment significantly.

Findings included:

- Record review for resident #115 revealed admission on 2-7-16 with diagnoses Parkinson's Disease, Weakness and Urinary Tract Infection.

The Functional Capacity Screen dated 2-7-16 recorded resident independent with eating and unable to perform bathing, dressing, toileting, transfers, walking/mobility and management of medications/treatments. Occasionally incontinent of bladder. Cognition: problems with decision-making. Current problems/risks identified: falls/unsteadiness and impaired decision-making.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 2-7-15 recorded the following staff assisted services:
Bathing (twice a week and as needed),
Dressing (AM and PM),
Toileting (every 3 hours and as needed with two person assist),
Transfers (two person assist with sit to stand lift),
Walking/Mobility(staff to propel wheelchair)
Management of Medications/Treatments (staff to administer as ordered)
Comments: Resident was living at home with (family). Transfers and weakening were noted ...admitted to hospital due to experiencing severe weakness after seeing neurologist. A Urinary Tract Infection was found, was unable to return home due to the need for a two person transfer.

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S 135	Continued From page 2 Resident Notes: 3-20-16 at 5:00 pm: "(Psychiatrist) here. (Resident) was examined. Admits to Depression. Lost (spouse) in December. Had to leave his/her home and family's care to come here. Admits to depression worse since admit here. Discontinue Effexor (antidepressant) and Wellbutrin (antidepressant). Start Wellbutrin XL 300 mg (milligrams) by mouth every morning for the depression." Signed by licensed staff C. Monthly Wellness Record: 3-27-16: "...a slight pattern of paranoia is developing ..." Signed by licensed staff C. 4-14-16: "Increased medications to include Prilosec (acid reducer). Given at home prior to admission ...Xanax (anti-anxiety) now twice a day (family's request) increased anxiety almost to hallucination/delusional thinking at times ..." Signed by licensed staff C. The record lacked documentation of notification of the primary care provider of medication changes prior to starting the new medication regimen and notification of any side effects the resident may have been experiencing upon abrupt discontinuation of the Effexor (antidepressant). Interview on 5-24-16 at 2:40 pm with the licensed staff C confirmed the physician had not been notified about the changes in medications prescribed by the psychiatrist and the resulting complaints of nausea, increased weakness and paranoia. For resident #115, the operator failed to ensure that designated facility staff consulted with the resident's primary care physician after being seen	S 135		

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S 135	Continued From page 3 by another physician and prior to starting a new medication regimen and also notified the resident's legal representative.	S 135		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 8 residents. The sample included 3 residents and 1 closed record review. Based on record review and interview for 2 (#115, #357) of 3 current residents sampled, the operator failed to ensure that each individual involved in the development of the Negotiated Service Agreement (NSA) signed the agreement. Findings included: - Record review for resident #115 revealed admission on 2-7-16 with diagnoses Parkinson ' s Disease, Weakness and Urinary Tract Infection. The Functional Capacity Screen dated 2-7-16 recorded resident required health care services. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 2-7-15 recorded services for staff assistance with	S3101		

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S3101	Continued From page 4 Bathing (twice a week), Dressing (AM/PM), Toileting (every 3 hours and as needed), Transfers (two persons with lift), Walking/Mobility (staff to propel wheelchair) and Management of Medications/Treatments (staff to administer). The NSA/HCSP lacked signatures for resident/responsible party. - Record review for resident #357 revealed admission on 10-13-15 with diagnoses Dementia, Malnutrition, Depression and Arthritis. The Functional Capacity Screen dated 4-9-16 recorded resident required health care services. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 4-9-16 recorded services for staff assistance with Bathing (twice a week), Dressing (supervision), and Management of Medications/Treatments (staff to administer). The NSA/HCSP lacked signatures for resident/responsible party. Interview on 5-24-16 at 4:30 pm with licensed staff C confirmed the NSAs lacked signatures for the resident and/or responsible party. For residents #115 and #357, the operator failed to ensure that each individual involved in the development of the Negotiated Service Agreement (NSA) signed the agreement.	S3101		
S3248 SS=D	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff	S3248		

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S3248	Continued From page 5 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)(1) The facility reported a census of 8 residents. The sample included 3 residents and one closed record review. The facility identified 24 employees hired since last resurvey, with 3 certified staff, 1 licensed staff and 1 non-certified staff reviewed. Based on record review and interview for 1 (#D) of 3 certified staff reviewed, the operator failed to ensure the employee records contained evidence of certification for	S3248		

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S3248	Continued From page 6 each employee performing a function that requires specialized education or training. Findings included: - Record review on 5-24-16 at 12:36 pm of employee record for certified staff #D (date of hire 8-29-15) lacked evidence of current medication aide certification. Employee file revealed certification expired on 5-13-16. Interview on 5-24-16 at 12:53 pm with Administrative staff #A confirmed certified staff #D's certification had expired on 5-13-16. Further confirmed he/she administered medications to all residents on 5-17-16, 5-18-16, 5-19-16, 5-23-16, and 5-24-16 without certification. Stated certified staff D and been asked to turn in the medication keys until he/she was re-certified. Stated, " the management company usually tracks the certifications and licenses. For certified staff D, the operator failed to ensure the employee records contained evidence of certification.	S3248		
S3255 SS=F	26-41-105 (b) Resident Records Confidential (b) Each administrator or operator shall ensure that all information in each resident's record, regardless of the form or storage method for the record, is kept confidential, unless release is required by any of the following: (1) Transfer of the resident to another health care facility; (2) law; (3) third-party payment contract; or (4) the resident or legal representative of the resident.	S3255		

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S3255	Continued From page 7 KAR 26-41-105(b) The facility reported a census of 8 residents. The sample included 3 residents and one closed record review. Based on observation and interview for all residents, the operator failed to ensure that all information in each resident's record, regardless of the form or storage method for the record, is kept confidential. Findings included: - Confidential Interview stated resident #115's record on 5-2-16 at 5:38 pm was observed by a visitor to be laying on a table in the unlocked foyer of the facility and accessible to any person entering the front door of the building. Interview on 5-24-16 at 12:44 pm with licensed staff C confirmed he/she laid the resident's record on the table in the foyer. Stated "I went to get my keys out of the work room and then got called away." Stated administrative staff A and administrative staff B looked at it on video surveillance footage and felt it laid out there for 10 minutes. Interview on 5-24-15 at 12:53 pm with administrative staff A confirmed the record had been left in the foyer by licensed staff C. Further confirmed the incident was not reported to the department. - Observation on 5-24-16 from around 2:35 pm until 3:49 pm revealed facility "Work Room" where resident charts are stored to be unlocked with door wide open. Majority of facility staff attending a staff meeting in adjacent room with door closed. Surveyor entered work room and obtained a resident record without staff	S3255		

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S3255	Continued From page 8 knowledge. Interview with certified staff E on 5-24-16 at 3:49 pm regarding the work room door stated, "It's always supposed to be closed and locked, that's why everyone has a key," then went and closed the door. Interview on 5-24-16 at 4:21 pm with licensed staff C confirmed the work room door should always be locked when no staff are inside to protect the confidentiality of the resident records. For all residents, the operator failed to ensure that all information in each resident's record, regardless of the form or storage method for the record is kept confidential.	S3255		