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 _____	07/07/2015

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

(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 an initial survey at the above named residential health care facility conducted on 6-30-15, 7-1-15, 7-6-15, and 7-7-15.	S 000		
S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a) The facility reported a census of 9 residents. The sample included 3 residents. Based on record review and interview for 1 (#154) of 1 sampled residents receiving insulin, the operator failed to ensure the negotiated service agreement provided a description of the services the resident will receive for diabetes management including	S3085		

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

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S3085	Continued From page 1	S3085		

identification of the provider of the services.

Findings included:

- Record review for resident #154 revealed admission on 8-24-14 with diagnoses Type 2 Diabetes Mellitus.

The Functional Capacity Screen dated 8-24-14 recorded resident unable to perform management of medications.

The Negotiated Service Agreement (NSA) dated 8-24-14 recorded services for facility staff to administer medications and treatments per physician ' s orders. The NSA lacked documentation of who performs blood glucose monitoring and administers insulin as ordered by the physician.

Physician order dated 12-23-14 for "blood glucose test once monthly on the 1st. Complete before breakfast." Results of blood glucose monitoring documented by CMAs (certified medication aides) on MAR (Medication Administration Record).

Review of MAR for July 2015 revealed:
Levemir Flexpen 100 units per M: 85 units subcutaneously daily for diabetes mellitus II. Administration of insulin initialed by CMAs (Certified Medication Aides).

Interview on 7-6-15 at 2:19 pm with licensed staff C stated CMAs perform monthly blood glucose monitoring and the nurses preset the Flexpen for CMAs to give to the resident to self-inject insulin. Confirmed the NSA lacked documentation for delegated certified staff to perform blood glucose monitoring and prepare Flexpen for resident to

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S3085	Continued From page 2 self-inject. For resident #154, the operator failed to ensure the negotiated service agreement provided a description of the services the resident will receive for diabetes management including identification of the provider of the services for blood glucose monitoring and preparation of insulin pens for administration.	S3085		
S3160 SS=G	26-41-204 (c) HEALTH CARE SERVICES (c) The health care services provided by or coordinated by a licensed nurse may include the following: (1) Personal care provided by direct care staff or by certified or licensed nursing staff employed by a home health agency or a hospice; (2) personal care provided gratuitously by friends or family members; and (3) supervised nursing care provided by, or under the guidance of, a licensed nurse. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(c)(1) The facility reported a census of 9 residents. The sample included 3 residents. Based on observation, record review and interview for 1 (#153) of 3 sampled residents, the operator failed to ensure the health care services coordinated by a licensed nurse which included personal care were provided by direct care staff or by certified or licensed nursing staff employed by a home	S3160		

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health agency licensed in Kansas. Resident #153, who required 2 person assist for all transfers, suffered a fractured femur when the private care giver attempted to transfer Resident #153 alone.

Findings included:

- Record review for resident #153 revealed admission on 8-18-14 with diagnoses Dementia, Debility, Depression, Hypothyroidism, Over Active Bladder, Degenerative Joint Disease, Obstructive Sleep Apnea, Congestive Heart Failure, Atrial Fibrillation and Coumadin Therapy.

The Functional Capacity Screen (FCS) dated 1-13-15 recorded resident unable to perform bathing, dressing, toileting, transfers, walking/mobility and management of medications/treatments; and independent with eating. Frequently incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision making. Current problems/risks identified: falls.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 1-13-15 recorded the following services:
Bathing: " (facility) staff will help resident to bathe ...will provide physical assistance to assure safe transfer to a shower chair to bathe ... "
Dressing: " (facility) staff will provide maximum physical assistance in the morning to dress and allow resident to choose from two outfits ... (facility) staff will remove clothes in the evening and put on pajamas ... "
Toileting: " (facility) staff will assure resident is toileted every three hours and as needed. (Resident) will be toileted prior to meals. Thorough pericare will be done after every toileting or incontinent episode ... "

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Transfer: " (facility) staff transfers resident with two person assist, and a sit to stand type mechanical lift. A floor lift device or a sling lift from the ceiling. "
Walking/Mobility: " Resident ' s ambulation is per wheelchair. He/She cannot self propel wheelchair at present. "
Eating: " Resident is independent in eating and has a good appetite. His/Her food is cut up into mouth size bites ... "
Management of Medications: " Facility staff will manage resident ' s medications. Certified Medication Aides and Nurses will administer medication ... "
The NSA recorded " Services to be provided at (facility) by outside service providers not on staff: 1:1 Care Attendants " per outside agency and a " Paid Personal Assistant " (not from the agency). Note: The NSA was signed by resident ' s Power of Attorney.

Resident Notes:
10-28-14 at 2:00 pm: " Resident lowered to the floor at 2:00 pm. Slowed down right leg fall. No apparent injury ...good range of motion to all extremities ...all staff enforce 2 people transfers even with sit to stand or sling lifts. " Signed by licensed staff C.
10-28-14 at 7:00 pm: " Private care giver attempted a one person transfer in spite of being aware of earlier fall. Resident fell onto his/her bottom by toilet ... " Signed by licensed staff C.
11-23-14 at 10:00 am: " Notified of resident ' s assisted fall ...being assisted by private sitter without facility assist at the time. Agency notified. Attendant to be trained on another device. " Signed by licensed staff C.
3-13-15 at 6:00 pm: " Went to resident ' s room to get him/her for dinner. Resident could be heard whimpering moderately, ' I can ' t do it, I

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can ' t do it. ' Upon entering bathroom, resident was being held up by her elastic waist pants ...I assisted to lower resident to the floor. Both knees were flexed facing towards the toilet. (Care giver) saying, ' It ' s entirely my fault, I thought he/she could do it ' . Resident was slid away from the wall ...right leg was painful. Deformed position to right of midline below knee. 911 called from room ...resident readied for safe transport. Legs stabilized together and splint applied to right lower leg. Swelling noted distal thigh. Ice was applied. Foot drop shoe splint removed by emergency medical technician. Resident had sensation to toes and could move them. Caregiver leaned against resident to sit him/her up until resident could be transferred to a spine board and put on stretcher. Resident called out occasional moderate tone of voice that touch/movement to right lower leg caused pain. " 3-14-15 at 9:36 am: " Caregiver texted: Broken femur above prosthetic knee ... " Signed by licensed staff C.

Observation on 7-1-15 at 1:17 pm revealed resident #153 in high back wheelchair with right knee brace on. Resident was transferred by two staff from wheelchair to bed with use of ceiling lift and sling.

Interview on 6-30-15 at 4:10 pm with licensed staff C stated resident #153 had a 1:1 sitter who acted as resident ' s power of attorney and was paid by the resident ' s family. Stated resident also had other private attendants who provided care from an agency. Stated resident #153 required 2 people to transfer him/her with a mechanical lift. Further stated that when the resident fell in March, the personal care attendant transferred him/her without asking for staff assistance and the resident experienced a

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fractured leg. Confirmed the outside caregivers were providing hands on care and further confirmed the facility lacked documentation that the outside caregivers had been provided training for transferring resident #153.

Interview on 7-1-15 around 4:30 pm with resident ' s private caregiver stated, " It ' s all my fault " and confirmed he/she was resident ' s power of attorney and the person who transferred resident in March without asking for assistance from facility staff. Stated he/she thought the resident could bear weight long enough to transfer. Also confirmed he/she was transferring resident without use of the lift. Stated he/she was a " P.A. or P.C.A.: personal attendant, or personal care attendant ...whichever you want to call it. " Confirmed he/she has transferred resident with one assist at other times.

Interviews on 7-1-15 at 11:07 am and 7-6-15 at 12:58 pm with administrative staff A confirmed resident #153 was a two person transfer upon admission to facility on 8-18-14 and stated resident was admitted as " heavy care " . Further confirmed that the private caregiver and the care attendants were not employed by an agency licensed as a home health care or hospice and lacked documentation the outside caregivers had been provided training for transferring resident #153.

For resident #153, the operator failed to ensure the health care services coordinated by a licensed nurse which included personal care were provided by direct care staff or by certified or licensed nursing staff employed by a home health agency licensed in Kansas. Resident #153, who required 2 person assist for all transfers, suffered a fractured femur when the private care giver

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S3160	Continued From page 7 attempted to transfer Resident #153 alone.	S3160		
S3201 SS=D	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(3)(A) The facility reported a census of 9 residents. The sample included 3 residents. Based on record review and interview for 1 (#154) of 3 sampled residents, the operator failed to ensure medication aides administered only the medication that the medication aides had personally prepared. Findings included:	S3201		

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S3201	Continued From page 8 - Record review for resident #154 revealed admission on 8-24-14 with diagnoses Type 2 Diabetes Mellitus. The Functional Capacity Screen dated 8-24-14 recorded resident unable to perform management of medications. The Negotiated Service Agreement (NSA) dated 8-24-14 recorded services for facility staff to administer medications and treatments per physician's orders. The NSA lacked documentation of who performs blood glucose monitoring and administers insulin as ordered by the physician. Review of MAR for July 2015 revealed: Levemir Flexpen 100 units per M: 85 units subcutaneously daily for diabetes mellitus II. Administration of insulin initialed by CMAs (Certified Medication Aides). Interview on 7-6-15 at 2:19 pm with licensed staff C stated the nurses preset the Levemir Flexpen for CMAs to hand to the resident; the CMAs observe resident self-inject the insulin then they remove and dispose of the needles. Confirmed Flexpens are preset (either the evening before administration, or the same morning of administration) by nurses for certified staff to hand to the resident so he/she can self-inject. For resident #154, the operator failed to ensure medication aides administered only the medication that the medication aides had personally prepared.	S3201		

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S3202	Continued From page 9	S3202		
S3202 SS=D	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 9 residents. The sample included 3 residents. Based on record review and interview for 1 (#154) of 1 sampled resident receiving blood glucose monitoring and/or insulin administration, the licensed nurse failed to appropriately delegate these nursing procedures under the Kansas Nurse Practice Act, KSA 65-1124 and amendments thereto by ensuring documentation related to the delegation of these nursing tasks was included in the personnel file of each designated medication aide. Findings included: - Record review for resident #154 revealed admission on 8-24-14 with diagnoses Type 2 Diabetes Mellitus. The Functional Capacity Screen dated 8-24-14 recorded resident unable to perform management of medications. The Negotiated Service Agreement (NSA) dated 8-24-14 recorded services for facility staff to administer medications and treatments per	S3202		

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S3202	Continued From page 10 physician's orders. The NSA lacked documentation of who performs blood glucose monitoring and administers insulin as ordered by the physician. Physician order dated 12-23-14 for "blood glucose test once monthly on the 1st. Complete before breakfast." Results of blood glucose monitoring documented by CMAs (certified medication aides) on MAR (Medication Administration Record). Review of MAR for July 2015 revealed: Levemir Flexpen 100 units per M: 85 units subcutaneously daily for diabetes mellitus II. Administration of insulin initialed by CMAs (Certified Medication Aides). Interview on 7-6-15 at 2:19 pm with licensed staff C stated CMAs perform monthly blood glucose monitoring and the nurses preset the Flexpen for CMAs to give to the resident to self-inject insulin. Confirmed the resident roster identified 1 resident currently receiving insulin injections. Interviews on 7-6-15 at 3:19 pm and 5:15 pm with administrative staff A confirmed the employee records for certified staff F, G, and H lacked documentation of competency checklists for preparation of insulin pens and performance of blood glucose monitoring. For resident #154 and potentially affecting all residents receiving blood glucose monitoring and/or insulin administration, the licensed nurse delegated certified medication aides to perform blood glucose monitoring and/or use of a preset insulin pen. The licensed nurse failed to appropriately delegate these nursing procedures to medication aides under the Kansas Nurse	S3202		

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S3202	Continued From page 11 Practice Act, K.S.A. 65-1124 by ensuring documentation related to the delegation of these nursing tasks was included in the personnel file of each designated medication aide.	S3202		
S3265 SS=J	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 9 residents. The sample included 3 residents. Based on record review and interview for 2 (#153, #154) of 3 sampled residents and 2 (#200, #201) non-sampled residents requiring 2 staff for transfer, the operator failed to ensure the provision of a sufficient number of staff on night shift to take residents who would require assistance to a secure location. This failure placed residents in this facility in immediate jeopardy related to insufficient staff available to take residents requiring assistance in an emergency or disaster during the night to a secure location. Findings included: - Review of the resident roster revealed a total resident census of 9 residents. The roster	S3265		

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S3265	Continued From page 12 identified 7 residents with impaired cognition and 4 residents who would require 2 staff for transfers with three of these residents also requiring the use of a mechanical lift. Interview during entrance tour on 6-30-15 at 3:40 pm with licensed staff C stated the following: Resident #153 was a 2 person transfer due to weakness in legs and used a mechanical lift; resident #154 was a 2 person transfer due to weak lower extremities and used a mechanical lift; resident #200 was a 2 person transfer because he/she had contractures and Kyphosis of the spine; and resident #201 was a 2 person transfer due to complications of spinal/cervical stenosis and used a sit to stand lift. Interview on 7-1-15 at 11:07 am with administrative staff A stated resident #153 moved to this facility as soon as it opened and was a two person transfer upon admission. Administrative staff A confirmed that there was 1 staff member routinely scheduled for the night shift (10 pm to 6 am and there is a " floater " who makes rounds at both facilities (this facility and separately licensed facility next door). Administrative staff A further stated from August 2014 to November 2014, the staff position was a " sleeper " who slept at this facility but beginning in November 2014 the position was changed to an awake staff that goes between the 2 facility. Confirmed that when the floater is at the other facility, there is only one certified staff member in this facility. Administrative staff A further stated they not conducted a drill that included evacuation of residents with the use of only 1 staff but had an evacuation to the safe room on 6-26-15 at approximately 1:30 a.m. due to a tornado warning. According to documentation provided by	S3265		

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S3265	Continued From page 13 the facility, the evacuation of 9 residents took 20 minutes. Interview on 7-7-15 at 11:52 am with licensed staff C confirmed that 2 staff participated in the evacuation of the residents on 6-26-15. Review of disaster and emergency preparedness education documented a review of the emergency management plan with staff on 5-13-15. For residents #153, #154, #200 and #201, the operator failed to 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 failure placed residents in this facility in immediate jeopardy related to insufficient staff available to take residents requiring assistance in an emergency or disaster during the night to a secure location. The jeopardy was removed on 7-1-15 when two staff were scheduled on duty at all times.	S3265		
S3290 SS=D	26-41-206 (a) (b) Dietary Services (a) Provision of dietary services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. If the administrator or operator of the facility establishes a contract with another entity to provide or coordinate the provision of dietary services to the residents, the administrator or operator shall ensure that entity ' s compliance	S3290		

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	N023021	A. BUILDING: _____ B. WING _____	07/07/2015

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

(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
S3290	Continued From page 14 with these regulations. (b) Staff. The supervisory responsibility for dietetic services shall be assigned to one employee. (1) A dietetic services supervisor or licensed dietician shall provide scheduled on-site supervision in each facility with 11 or more residents. (2) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(a)(b)(2) The facility reported a census of 9 residents. The sample included 3 residents. Based on observation, record review and interview for 1 (#152) of 3 sampled residents, the operator failed to ensure the resident's mechanically altered therapeutic diet shall be prepared according to instructions from a medical care provider or licensed dietitian. Findings included: - Record review for resident #152 revealed admission on 6-11-15 with diagnoses of Esophageal Cancer, Hypertension, and Atrial Fibrillation. The Functional Capacity Screen dated 6-11-15	S3290		

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S3290	Continued From page 15	S3290		

recorded resident unable to perform bathing, dressing, toileting, transfers, walking/mobility, eating, and management of medications/treatments. Continent of bladder. No problems with cognition.

Physician's order sheet dated 6-11-14 stated: Soft, Regular, Full Liquid, Pureed diet.

Physician's Progress Note dated 6-22-15 stated the following regarding resident's diet: "(Speech Therapist) is calling to give report on patient. He/She went out to visit resident today for additional teaching to patient's family and facility staff so everyone 'is on the same page.' Speech Therapist wants to make sure nothing has changed about the patient's current order. The order is for a pureed/liquid diet. Solid food was discontinued in April by physician's order due to esophageal problems with swallowing and past cancer diagnosis. This has not changed, correct? Speech Therapist's understanding is that solid food will not be attempted for this patient." Signed by nurse and physician.

Interview on 6-30-15 at 4:10 pm with licensed staff C stated resident has a feeding tube (Jevity) managed by staff and is still taking in some oral foods.

Observation of lunch on 7-1-15 at 12:10 pm revealed resident sitting at table and feeding self tomato soup followed by ice cream without difficulty. Occasional cough.

Interview on 7-1-15 at 12:15 pm of dietary staff E stated resident gets a soft scrambled egg for breakfast and for lunch gets different soups and ice cream; they occasionally may puree something for the resident depending on what

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S3290	Continued From page 16 resident wants. Confirmed the facility lacked written instructions for preparing a mechanically altered therapeutic diet (soft and/or pureed foods) for the resident. For resident #152, the operator failed to ensure the resident's mechanically altered therapeutic diet was prepared according to instructions from a medical care provider or licensed dietitian.	S3290		