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PARK MEADOWS MEMORY CARE	5951 W 107TH STREET OVERLAND PARK, KS 66207

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaint investigations 130454, 128654, 125515, 122370, 119211 at the above named residential health care facility conducted on 10-22-18, 10-23-18, 10-24-18, 10-25-18 and 10-29-18.	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.	S3028		

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

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101((f)(3)(A)(F) The facility reported a census of 21 residents. The sample included 3 residents and two closed record reviews. Based on record review and interview for 1 (#401) of 2 closed record reviews, the administrator failed to ensure each allegation of abuse and neglect shall be reported to the department within 24 hours and investigated in order to rule out abuse or neglect. Findings included: - Record review for Resident #401 revealed admission on 12-10-17 with diagnoses Alzheimer's Dementia, Hypertension, Glaucoma, Vitamin D and B-12 deficiencies, Osteoarthritis and Depression The Functional Capacity Screen dated 12-2-17 recorded resident required physical assistance with bathing, dressing, and toileting; supervision with transfers, walking/mobility, eating; and unable to perform management of medications and treatments. Occasionally incontinent of bladder. Communication: sometimes understandable; sometimes understands. Cognition: left blank. Current problems included: impaired vision and impaired decision-making. No assistive devices used. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 12-13-17 recorded services for assistance with physical assistance with dressing, bathing and toileting. Reminders for meals. The NSA/HCSP lacked information regarding medication management.	S3028		

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S3028	Continued From page 2 Review of Nurse's Notes revealed the following: 12-18-17 at 1:15 pm: "At lunch time when the resident was sitting in the chair in the dining room I saw the resident wiping his/her hands when I looked I saw blood coming from skin tear on his/her left forearm." Signed by Certified Staff L. The record lacked documentation of assessment by a licensed nurse and investigation into cause of the injury. The facility further lacked documentation that the inury of unknown origin was reported to the department and investigated to rule out abuse or neglect. Interview on 10-24-18 at 10:45 am with Licensed Staff B confirmed regarding the injury of unknown origin experienced on 12-18-17, the record lacked documentation of assessment and investigation by a licensed nurse. Confirmed family members had expressed concern regarding the skin tear. Confirmed the facility had failed to report the injury of unknown origin and lacked documentation of an investigation conducted to rule out abuse or neglect. For Resident #401, the administrator failed to ensure each allegation of abuse and neglect shall be reported to the department within 24 hours and investigated in order to rule out abuse or neglect. The administrator further failed to ensure a written record of each investigation shall be maintained.	S3028		
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	S3200		

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S3200	Continued From page 3 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: K.A.R. 26-41-205(d) The facility reported a census of 21 residents. The sample included 3 residents and 2 closed record reviews. Based on record review and interview for 2 (#119, #233) of 3 sampled residents and 1 (#401) of 2 closed record review residents, the administrator failed to ensure that all medications and biologicals are administered in accordance with a medical care providers written order and professional standards of practice. Findings included: - Record review for Resident #119 revealed admission on 6-13-13 with diagnoses Alzheimer's Disease, Hypertension, Gastroesophageal Reflux Disease, and Hyperlipidemia.	S3200		

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S3200	Continued From page 4 The Functional Capacity Screen dated 7-31-18 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement/Health Care Service Plan dated 7-31-18 recorded services for Medication Management to include assistance with oral, inhaled or topical medications and to be monitored by a licensed nurse. Facility staff "will assist the resident to take medications, will order medications from the pharmacy, store medications and monitor for side effects. Review of Medication Administration Record for September 2018 revealed the following controlled substance medications administered on an as needed basis: Lorazepam concentrate 2 mg/ml (milligrams/milliliter) Give 0.25 ml by mouth every two hours as needed. (the order lacked an indication/reason for use). Certified Medication Aide (CMA) #E documented he/she administered the medication on 10-10-18 at 12:30 and 10-15-18 at 10:23 pm for "agitation". CMA #F documented he/she administered the medication on 10-19-18 at 5:37 pm for undocumented reason. The record lacked documentation that the controlled substance medication was administered following an assessment and instruction by a licensed nurse. The record further lacked documentation of an assessment and follow up for effectiveness by a licensed nurse. Morphine Sulfate solution 100 mg/5 ml Give 0.25 ml by mouth every 2 hours as needed for pain or air hunger. CMA #E documented he/she administered the medication on 10-10-18 for "pain". CMA #F documented he/she administered	S3200		

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the medication on 10-19-18 at 5:37 pm (same time Lorazepam was given) for undocumented reason. The record lacked documentation that the controlled substance was administered following an assessment and instruction by a licensed nurse. The record lacked documentation of an assessment and follow up for effectiveness by a licensed nurse.

Interview on 10-22-18 at 3:45 pm with Licensed Staff #B confirmed the record lacked documentation that CMAs consulted with licensed staff prior to giving narcotic medications on an "as needed" basis and also confirmed that the resident would have to be assessed beforehand to determine the medication was necessary. Further confirmed the record lacked documentation of follow up by a licensed nurse for effectiveness of the medication.

- Record review for Resident #233 revealed admission on 9-14-18 with diagnoses Hyperlipidemia, Atherosclerotic Disease, Anemia, Pathological Fracture due to Osteoporosis, Acid Regurgitation,Vitamin D Deficiency, Atrial fibrillation, Hypothyroidism, Chronic Renal Disease, Vascular Dementia, Muscle Hypotonia, Abnormal Gait and Communicative Disorder.

The record lacked documentation of a functional capacity screening.

The Negotiated Service Agreement/Health Care Service Plan dated 10-15-18 and signed only by Licensed Staff B recorded services for Medication Management to include assistance with oral, inhaled or topical medications and to be monitored by a licensed nurse. Facility staff "will assist the resident to take medications, will order

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medications from the pharmacy, store medications and monitor for side effects.

Review of Medication Administration Record for September 2018 revealed the following controlled substance medications administered on an as needed basis:

Hydrocodone/acetaminophen 5/325 mg (milligrams) Take one tablet by mouth every 6 hours as needed for pain. Certified Medication Aide (CMA) #H documented he/she administered medication on 10-4-18 at 5:42 am. CMA #F documented he/she administered the medication on 10-6-18 at 7:03 am (no reason given), 10-12-18 at 3:27 pm (back pain), 10-14-18 at 7:19 pm (no reason given), 10-15-18 at 5:45 pm (no reason given) and 10-19-18 at 5:40 pm (no reason given). CMA #G documented he/she administered the medication on 10-16-18 at 12:23 pm (pain on the bottom).

Lorazepam 1 mg (milligram) Give 1 tablet by mouth every six hours as needed (the order lacked an indication/reason for use). Certified Medication Aide (CMA) #G documented he/she administered the medication on 10-2-18 at 8:55 am (no reason given). CMA #F documented he/she administered the medication on 10-3-18 at 5:58 pm and 10-4-18 at 4:35 pm (no reason given).

Lorazepam 0.5 mg Take 1/2 tablet (0.25 mg) by mouth every 6 hours as needed for Agitation or Anxiety. CMA #F documented he/she administer the medication on 10-6-18 at 6:29 am (no reason given); 10-8-18 at 7:27 pm (no reason given); 10-9-18 at 6:43 pm (no reason given); 10-10-18 at 10:05 pm (no reason given); 10-12-18 at 3:28 pm (no reason given); 10-14-18 at 7:19 pm (no

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reason given); 10-15-18 at 5:45 pm (no reason given); 10-19-18 at 5:40 pm (no reason given).

The record lacked documentation that the controlled medications were administered following an assessment and instruction by a licensed nurse. The record further lacked documentation of an assessment and follow up by a licensed nurse for effectiveness.

Interviews on 10-22-18 at 3:49 pm and 10-25-18 at 11:50 am with Licensed Staff #B confirmed the medications were administered by certified staff and the records lacked documentation that CMAs consulted with licensed staff prior to giving narcotic medications on an "as needed" basis and that the resident would have to be assessed beforehand to determine the medication was necessary. Further confirmed the record lacked documentation of follow up by a licensed nurse for effectiveness of the medication.

For Residents #119 and #233, the administrator failed to ensure that all medications and biologicals are administered in accordance with a medical care providers written order and professional standards of practice.

- Record review for Resident #401 revealed admission on 12-10-17 with diagnoses Alzheimer's Dementia, Hypertension, Glaucoma, Vitamin D and B-12 deficiencies, Osteoarthritis and Depression

The Functional Capacity Screen dated 12-2-17 recorded resident unable to perform management of medications and treatments.

The Negotiated Service Agreement/Health Care

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S3200	Continued From page 8 Service Plan dated 12-13-17 lacked information regarding medication management. Physician orders signed on 11-29-17 for the following medications: Memantine 10 mg (milligrams) twice daily for Senile Dementia Alzheimer's Type. Lisinopril 10 mg daily for Hypertension. Vitamin B-12 2000 micrograms twice a day for supplement. Vitamin D-3 2000 units daily for supplement. Latanoprost 2.5% eye drops 1 drop both eyes in evening for Glaucoma. Brimonidine solution 0.2%, 1 drop right eye twice a day for Glaucoma. Aspirin 81 mg every evening for supplement. Bupropion 150 mg once daily for Senile Dementia Alzheimer's Type. Review of Medication Administration Record for December 2017 lacked documentation of any medication being administered until 8:00 am on 12-20-17; and provided documentation of Brimonidine 0.2% eye drops being administered only once a day at 8:00 pm until 12-29-17 when staff began administering twice a day as ordered. Nurse's notes dated 12-17-17 at 9:00 pm: "Resident admitted to (facility)...had missing medications, (family member) informed and stated will bring tomorrow, medication list faxed to the pharmacy..." Signed by Licensed Staff D. Interview on 10-24-18 at 10:54 am with Licensed Staff B confirmed the resident failed to receive medications as ordered by the physician and further confirmed the record lacked documentation that the physician was notified that the resident did not receive his/her medications.	S3200		

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S3200	Continued From page 9 For Resident #401, the administrator failed to ensure medications and biologicals were administered in accordance with the medical care provider's written orders.	S3200		
S3227 SS=F	26-41-205 (l) (2) Medication Regimen Review Variance Report (l) (2) The licensed pharmacist or licensed nurse shall notify the medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist shall notify a licensed nurse within 48 hours of any variance identified in the resident ' s regimen review that does not require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident ' s medical care provider. The licensed nurse shall seek a response from the medical care provider within five working days of the medical care provider ' s notification of a variance. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(l)(2) The facility reported a census of 21 residents. The sample included 3 residents and 2 closed record reviews. The licensed nurse failed to seek a response from the medical care provider upon discovery of a variance identified in the medication regimen review based on record review and interview for 2 of 2 sampled residents and affecting all residents with facility managed medications.	S3227		

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S3227	Continued From page 10 Findings included: - Record review for Resident #119 revealed admission on 6-13-13 with diagnoses Gastroesophageal Reflux Disease, Alzheimer's Disease, Hyperlipidemia and Hypertension. The Functional Capacity Screen dated 7-31-18 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement/Health Care Service Plan dated 7-31-18 recorded services for Medication Management to include assistance with oral, inhaled or topical medications and to be monitored by a licensed nurse. Facility staff "will assist the resident to take medications, will order medications from the pharmacy, store medications and monitor for side effects. The record contained a signature page for consulting pharmacists to sign and provide notes for medication regimen reviews. The reviews were signed as performed on 12-31-16, 3-15-17, 6-27-17, 9-19-17, 12-18-17, 3-19-18, 6-19-18 and 9-11-18. On 10-23-18, Licensed Staff B printed from email and provided medication regimen review reports for 2018. For Resident #119, on a report dated 9-11-18, the consulting pharmacist recommended discontinuing duplicate therapy using Alprazolam and Lorazepam, both of which are anti-anxiety medications. The report lacked documentation of notification of the physician. - Record review for Resident #306 revealed admission on 7-24-15 with diagnoses Alzheimer's	S3227		

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Disease, Dementia, Auditory Impairment, Depression, Hyperlipidemia, Hypothyroidism, Anxiety, Hypertension, and Vitamins B-12 and D Deficiencies.

The Functional Capacity Screen dated 5-8-18 recorded resident unable to perform management of medications and treatments.

The Negotiated Service Agreement/Health Care Service Plan dated 10-18-18 recorded services for Medication Management to include assistance with oral, inhaled or topical medications and to be monitored by a licensed nurse. Facility staff "will assist the resident to take medications, will order medications from the pharmacy, store medications and monitor for side effects.

The record contained a signature page for consulting pharmacists to sign and provide notes for medication regimen reviews. The reviews were signed as performed on 12-31-16, 3-15-17, 6-27-17, 9-19-17, 12-18-17, 3-19-18, 6-19-18 and 9-11-18 with minimal notes by pharmacist.

On 10-23-18,Licensed Staff B printed from email and provided medication regimen review reports for 2018. For Resident #306, on a report dated 9-11-18, the consulting pharmacist recommended physician discontinue unused PRN (as needed) medications due to non-use stating "failure to address discontinuing of unused PRN medications may result in staff reordering an expired medication that should have been discontinued."

Interviews on 10-22-18 at 10:00 am and on 10-23-18 at 2:41 pm with Licensed Staff B confirmed he/she had not performed any type of follow up for any of the facility residents regarding

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S3227	Continued From page 12 the medication regimen reviews. Stated he/she remembers seeing reports from the pharmacist in his/her emails but did not know what to do with the reports and had not notified the physicians of any variances or pharmacist's recommendations. For Residents #119, #306 and affecting all residents, the licensed nurse failed to seek a response from the medical care provider upon discovery of a variance identified in the medication regimen review.	S3227		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3)	S3280		

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S3280	Continued From page 13 The facility reported a census of 21 residents. The sample included 3 residents and 2 closed record reviews. Based on record review and interview for all residents and all facility employees, the administrator failed to ensure disaster and emergency preparedness by ensuring quarterly review of the facility's emergency management plan with all employees and residents; and ensuring performance of an emergency drill annually that included evacuation of the residents to a secure location. Findings included: - Review on 10-23-18 at 4:15 pm of the facility's emergency management plan notebook and staff inservice notebooks with Administrative Staff J, revealed the facility lacked documentation of quarterly review of all components of the emergency management plan with residents and employees and performance of an annual full facility evacuation. Administrative Staff J provided copy of staff inservice for Fire Safety on 2-27-17. Interview on 10-24-18 at 10:15 am with Administrative Staff K confirmed he/she had not performed a full evacuation of the facility since he/she had started working at facility in April 2018 and was unable to provide documentation of a quarterly review of the emergency plan with staff or residents. For all residents and employees, the administrator failed to ensure emergency preparedness by ensuring quarterly review of the emergency management plan and performance of an emergency drill that included evacuation of the residents to a secure location.	S3280		