STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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 a resurvey of the above assisted living facility on 5/22/14, 5/27/14, 5/28/14, and 5/29/14.	S 000		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 27 residents. The sample included 3 residents. Based on record review and interview for 1 (#450), the operator/licensed nurse failed to ensure the resident's functional capacity for the management of medications and treatments was accurately reflected on the resident's screening form. Findings included: - Record review for resident #450 revealed an admission date of 12/29/12 and diagnoses of hypertension and osteoporosis. According to the resident roster, resident #450 self-administered medications. The functional capacity screen dated 12/29/13 indicated the resident was unable to perform management of medications and treatments. The negotiated service agreement dated	S3082		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3082	Continued From page 1 12/29/13 lacked documentation that the facility managed the resident's medications and treatments or that the resident independently managed medications and treatments. At 3:40 p.m. on 5/27/14, the operator/licensed nurse stated the resident stored and self-administered medications. Operator/licensed nurse confirmed the functional capacity screen was inaccurate for the resident's ability to manage medications and treatments. The operator/licensed nurse failed to ensure resident #450's functional capacity for the management of medications and treatments was accurately reflected on the resident's screening form.	S3082		
S3085 SS=F	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.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3085	Continued From page 2	S3085		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-202(a)(1)(2)(3)

The facility reported a census of 27 residents. The sample included 3 residents. Based on record review, interview, and observation for 1 (#452) of 3 residents sampled, the operator/licensed nurse failed to develop a written negotiated service agreement (NSA) for the resident based on the functional capacity screen (FCS), service needs and preferences of the resident that included a description of services the resident would receive, the provider of the services, and the identification of the party responsible for payment when services were provided by an outside resource. Based on record review and interview for 2 (#450 and #451) of 3 residents sampled, the operator/licensed nurse failed to develop a written NSA for each resident based on the FCS, service needs and preferences of the resident that included a description of services the resident would receive and the provider of the services.

Findings included:

- Record review for resident #452 revealed an admission date of 12/12/12 and diagnoses of type II diabetes mellitus, arthritis, anemia, and hypertension.

The FCS dated 10/25/13 indicated the resident required physical assistance with bathing and dressing; supervision with toileting, transferring, and walking; independent with eating; unable to perform medication and treatment management; and experienced impaired short-term memory,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3085	Continued From page 3	S3085		

decision making, and memory recall.

The NSA 10/25/13 documented the services of physical assistance with bathing and putting on compression stockings; stand-by assistance with transfers and walking with walker; and staff administration of medications. The NSA services related to the resident's risk for falls of check on resident every 2 hours, room free of obstacles, call bell in reach, and night light.

Review of the May 2014 medication administration record revealed the resident received Lantus insulin 35 units subcutaneously (SQ) every night at bedtime and Humalog 10 units SQ before breakfast and lunch and 15 units SQ before supper if blood sugar level was over 150.

At 10:00 a.m. on 5/22/14, certified medication aide (CMA) #A stated resident self-administered insulin.

At 11:50 a.m. on 5/22/14, observed CMA #A assist resident to test blood sugar level with a glucometer with result of 142. CMA #A stated resident did not require insulin when blood sugar level was below 150. CMA #A stated that if resident's blood sugar was over 150, then resident drew up insulin into a syringe and self-administered insulin. Resident #452 confirmed he/she prepared insulin syringe and self-administered insulin when blood sugar level was over 150.

The NSA lacked a description of services for the administration of insulin and the provider of the service.

At 4:05 p.m. on 5/27/14, the operator/licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3085	Continued From page 4	S3085		

nurse confirmed the NSA lacked a description of services that the resident drew up insulin into a syringe and self-administered.

The interdisciplinary notes contained documentation by the operator/licensed nurse on 5/8/14 that the resident complained of shoulder pain from a fall and therapist to ask for a referral.

During an interview at 2:30 p.m. on 5/27/14, resident stated he/she received therapy services for exercising.

At 4:10 p.m. on 5/27/14, the operator/licensed nurse stated resident received physical therapy from an outside resource and confirmed the resident's NSA lacked a description of this service, the provider of the service, and the party responsible for payment of the service.

The operator/licensed nurse failed to develop a written NSA for resident #452 based on the resident's FCS, service needs and preferences of the resident that included a description of services the resident would receive, the provider of the services, and the identification of the party responsible for payment when services were provided by an outside resource.

- Review of the resident roster revealed resident #450 self-administered medications.

Record review for resident #450 revealed an admission date of 12/29/12 and diagnoses of hypertension and osteoporosis.

The FCS dated 12/29/13 indicated the resident was unable to perform management of medications and treatments and was at risk for falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3085	Continued From page 5 The NSA dated 12/29/13 lacked a description of services for medication management by the resident or the facility. The NSA lacked a description of services related to the resident's risk for falls. During an interview at 2:50 p.m. on 5/27/14, resident stated he/she stored medications, self-administered medications, and reordered medications. Resident stated he/she had fallen 3 or 4 times. At 3:40 p.m. on 5/27/14, operator/licensed nurse confirmed the resident's NSA lacked a description of services for medication management and resident's risk for falls. The operator/licensed nurse failed to develop a written NSA for resident #450 based on the FCS, service needs and preferences of the resident that included a description of services the resident would receive and the provider of the services. - Record review for resident #451 revealed an admission date of 5/1/12 and diagnoses of mild dementia and depression. The FCS dated 5/1/13 indicated the resident was at risk for falls and experienced impaired short-term memory, decision making, and memory recall. The NSA dated 5/1/13 lacked a description of services related to the resident risk for falls. The interdisciplinary notes contained documentation the resident's falls with most recent fall on 4/30/14 when fell coming out of	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3085	Continued From page 6 bathroom and received a laceration above left eye. At 3:50 p.m. on 5/27/14, the operator/licensed nurse confirmed the resident's NSA lacked a description of services related to the resident's risk for falls. The operator/licensed nurse failed to develop a written NSA for resident #451 based on the FCS, service needs and preferences of the resident that included a description of services the resident would receive and the provider of the services.	S3085		
S3105 SS=D	26-41-202 (j) Negotiated Service Agreement Outside Resource (j) If a resident's negotiated service agreement includes the use of outside resources, the designated facility staff shall perform the following: (1) Provide the resident, 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, with a list of providers available to provide needed services; (2) assist the resident, if requested, in contacting outside resources for services; and (3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice This REQUIREMENT is not met as evidenced by: KAR 26-41-202(j)(3)	S3105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3105	Continued From page 7	S3105		

The facility reported a census of 27 residents. The sample included 3 residents. Based on record review and interview for 1 (#452) of 3 residents sampled, the operator/licensed nurse failed to monitor services provided by an outside resource.

Findings included:

- Review of the resident roster revealed resident #452 received services from an outside resource.

Record review for resident #452 revealed an admission date of 12/12/12 and diagnoses of type II diabetes mellitus, arthritis, anemia, and hypertension.

The functional capacity screen dated 10/25/13 indicated the resident required physical assistance with bathing and dressing; supervision with toileting, transferring, and walking; independent with eating; unable to perform medication and treatment management; and experienced impaired short-term memory, decision making, and memory recall.

The negotiated service agreement dated 10/25/13 documented the services of physical assistance with bathing and putting on compression stockings; stand-by assistance with transfers and walking with walker; and staff administration of medications. The negotiated service agreement contained services related to the resident's risk for falls of check on resident every 2 hours, room free of obstacles, call bell in reach, and night light. The negotiated service agreement lacked a description of services provided by an outside resource.

The interdisciplinary notes contained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3105	Continued From page 8 documentation by the operator/licensed nurse on 5/8/14 that the resident complained of shoulder pain from a fall and therapist to ask for a referral. During an interview at 2:30 p.m. on 5/27/14, resident stated he/she received therapy services for exercising. At 9:30 a.m. on 5/28/14, the operator/licensed nurse stated resident received physical therapy from an outside resource. Operator/licensed nurse stated there was not a system in place to monitor the services provided by an outside resource and "Just assume they do what they are supposed to do." The operator/licensed nurse failed to monitor services provided to resident #452 by an outside resource.	S3105		
S3171 SS=F	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The facility reported a census of 27 residents. The sample included 3 residents. Based on record review and interview for 3 (#451, #450, and #452) of 3 residents sampled, the operator/licensed nurse failed to ensure health care services were provided to residents by qualified staff in accordance with acceptable standards of practice when a licensed nurse	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3171	Continued From page 9	S3171		

instructed certified staff to assess resident after a fall and failed to complete a nursing assessment of the resident.

Findings included:

- Record review for resident #451 revealed an admission date of 5/1/12 and diagnoses of mild dementia and depression.

The functional capacity screen dated 5/1/13 indicated the resident was at risk for falls; was independent with transferring, walking, and eating; required supervision with dressing and toileting; required physical assistance with bathing; was unable to perform medication and treatment management; and experienced impaired short-term memory, decision making, and memory recall.

The negotiated service agreement dated 5/1/13 contained a description of services for bathing assistance; assistance with putting on support stockings; toileted self; transferred self; walked by self with walker; independent with eating; and staff administration of medications. The negotiated service agreement dated 5/1/13 lacked a description of services related to the resident risk for falls.

The interdisciplinary notes contained documentation of the resident experiencing a fall without a nursing assessment by a licensed nurse as follows:

10/6/12 3:00 p.m. to 11:00 p.m. shift documented by a certified medication aide (CMA) that resident's family member called the facility phone to report resident had fallen. CMA documented notification of the licensed nurse and resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3171	Continued From page 10	S3171		

complained of sore knees, back, and body aches. The record lacked a licensed nurse assessment of the resident.

10/10/12 11:00 p.m. to 7:00 a.m. shift documentation by a CMA that he/she heard resident calling and found resident on floor in the hallway. CMA documented resident had a rug burn on right buttock and notified the licensed nurse who did a "phone assessment." The record lacked a licensed nurse assessment of the resident.

4/7/13 3:00 p.m. to 11:00 p.m. shift CMA documented resident on the floor, called licensed nurse who helped CMA "do assessment" of resident. The record lacked a licensed nurse assessment of the resident.

6/27/13 at 5:00 a.m. CMA heard noise in resident's room and found resident on the floor. CMA documented he/she called licensed nurse who "listened as I got (resident) off the floor." The record lacked a licensed nurse assessment of the resident.

7/13/13 at 4:30 p.m. CMA documented resident on the floor and assisted resident up. Licensed nurse notified by CMA of resident's fall. The licensed nurse did not document an assessment of the resident until 7/16/13.

9/20/13 CMA documented that at 3:30 p.m. the resident's family member came to report resident had fallen in bathroom. CMA documented resident fell and hit right side on the corner of a chair. CMA documented notification of the licensed nurse. The record lacked a licensed nurse assessment of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3171	Continued From page 11 2/8/14 7:00 a.m. to 3:00 p.m. shift CMA documented finding a bruise on resident's right hip and "starting to swell." CMA documented resident did not want to get out of bed due to pain and pain when bearing weight. CMA documented no reports of resident falling. Resident's family member took resident to hospital for evaluation and CMA documented "nothing broke." The record lacked documentation of licensed nurse assessment of the resident on this date. 2/10/14 7:00 a.m. to 3:00 p.m. Operator/licensed nurse documented staff called him/her regarding the bruise on the resident's hip. Operator/licensed nurse documented "Had staff put (resident) on (resident's) back and see if one leg was longer and/or one leg abducting, due to inability to bear weight without being in excruciating pain. Had family take to ER." 4/30/14 3:00 p.m. to 11:00 p.m. shift CMA documented family member came to CMA to report resident fell coming out of bathroom. CMA documented resident had blood running down face and CMA cleansed area and applied a steri-strip to the cut above left eye. CMA documented eye turning black and blue and nurse notified. On 5/1/14 7:00 a.m. to 3:00 p.m. shift, the operator/licensed nurse documented resident's left side of face "very bruised and puffy." At 3:40 p.m. on 5/27/14, the operator/licensed nurse stated that when a resident hit head when falling, he/she "walk the (CMAs) through a neuro-check" of the resident. Operator/licensed nurse explained that he/she instructed CMA to have resident squeeze the CMA's hands and talk to the CMA and CMA followed up with frequent checks of resident to see if resident awake.	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3171	Continued From page 12 At 4:00 p.m. on 5/27/14, operator/licensed nurse stated CMAs were instructed to call him/her prior to getting a resident up after a fall. Operator/licensed nurse stated while on the phone with the CMA he/she listened to the resident as the CMA assisted resident up to determine if resident in pain. Operator/licensed nurse stated he/she assessed resident on the phone based on information provided by the CMA. Operator/licensed nurse confirmed a licensed nurse did not perform a nursing assessment of the resident after the resident experienced a fall. For resident #451, the operator/licensed nurse failed to ensure health care services were provided to the resident by qualified staff in accordance with acceptable standards of practice when a licensed nurse instructed certified staff to assess resident after a fall and failed to complete a nursing assessment of the resident. - Record review for resident #450 revealed an admission date of 12/29/12 and diagnoses of hypertension and osteoporosis. The functional capacity screen dated 12/29/13 indicated the resident was independent with bathing, dressing, toileting, transferring, walking, and eating; was unable to perform management of medications and treatments; and was at risk for falls. The negotiated service agreement dated 12/29/13 lacked a description of services related to the resident's risk for falls. The interdisciplinary notes contained documentation of the resident experiencing a fall	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3171	Continued From page 13 without a nursing assessment by a licensed nurse as follows: 6/7/13 3:00 p.m. to 11:00 p.m. shift certified medication aide (CMA) documented resident put on call light to report had fallen. CMA documented resident had a small bruise to left elbow. The record lacked a licensed nurse assessment of the resident. 6/17/13 at 9:15 p.m. a CMA documented the resident reported he/she fell in closet and hit head on wall. CMA documented he/she checked the resident for bruising and notified the licensed nurse. The licensed nurse documented on the 7:00 to 3:00 p.m. shift 6/18/13 that resident had no bruises or complaints. At 3:40 p.m. on 5/27/14, the operator/licensed nurse stated that when a resident hit head when falling, he/she "walk the (CMAs) through a neuro-check" of the resident. Operator/licensed nurse explained that he/she instructed CMA to have resident squeeze the CMA's hands and talk to the CMA and CMA follow-up with frequent checks of resident to see if resident awake. At 4:00 p.m. on 5/27/14, operator/licensed nurse stated CMAs were instructed to call him/her prior to getting a resident up after a fall. Operator/licensed nurse stated while on the phone with the CMA he/she listened to the resident as the CMA assisted resident up to determine if resident in pain. Operator/licensed nurse stated he/she assessed resident on the phone based on information provided by the CMA. Operator/licensed nurse confirmed a licensed nurse did not perform a nursing assessment of the resident after the resident experienced a fall.	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3171	Continued From page 14 For resident #450, the operator/licensed nurse failed to ensure health care services were provided to resident by qualified staff in accordance with acceptable standards of practice when a licensed nurse instructed certified staff to assess resident after a fall and failed to complete a nursing assessment of the resident. - Record review for resident #452 revealed an admission date of 12/12/12 and diagnoses of type II diabetes mellitus, arthritis, anemia, and hypertension. The functional capacity screen dated 10/25/13 indicated the resident required physical assistance with bathing and dressing; supervision with toileting, transferring, and walking; independent with eating; unable to perform medication and treatment management; and experienced impaired short-term memory, decision making, and memory recall. The negotiated service agreement dated 10/25/13 documented the services of physical assistance with bathing and putting on compression stockings; stand-by assistance with transfers and walking with walker; and staff administration of medications. The negotiated service agreement contained services related to the resident's risk for falls of check on resident every 2 hours, room free of obstacles, call bell in reach, and night light. The interdisciplinary notes contained documentation of the resident experiencing a fall without a nursing assessment by a licensed nurse as follows: 8/3/13 certified medication aide (CMA)	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3171	Continued From page 15 documented at 3:29 p.m. that resident put call light on and had fallen. CMA called licensed nurse who did "phone assessment." CMA documented he/she used a mechanical lift to get resident up and gave resident pain medication for complaint of hip pain. CMA documented "Resident was not hurt." The record lacked a licensed nurse assessment of the resident. 10/19/13 11:00 p.m. to 7:00 a.m. shift CMA documented resident fell in bathroom and received a skin tear to left elbow. CMA documented "No apparent injuries." Licensed nurse notified and completed a "verbal assessment." CMA used mechanical lift to get resident up from floor. The record lacked a licensed nurse assessment of the resident. At 4:00 p.m. on 5/27/14, operator/licensed nurse stated CMAs were instructed to call him/her prior to getting a resident up after a fall. Operator/licensed nurse stated while on the phone with the CMA he/she listened to the resident as the CMA assisted resident up to determine if resident in pain. Operator/licensed nurse stated he/she assessed resident on the phone based on information provided by the CMA. Operator/licensed nurse confirmed a licensed nurse did not perform a nursing assessment of the resident after the resident experienced a fall. For resident #452, the operator/licensed nurse failed to ensure health care services were provided to resident by qualified staff in accordance with acceptable standards of practice when a licensed nurse instructed certified staff to assess resident after a fall and failed to complete a nursing assessment of the resident.	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3175	Continued From page 16	S3175		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 27 residents. The sample included 3 residents. Based on record review, interview, and observation for 1 (#452) of 3 residents sampled, the operator/licensed nurse failed to conduct an assessment of the resident's ability to prepare and self-administer insulin at least annually and when the resident experienced a significant change of condition. Findings included:	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3175	Continued From page 17	S3175		

- Record review for resident #452 revealed an admission date of 12/12/12 and a diagnosis of type II diabetes mellitus.

The significant change functional capacity screen dated 10/25/13 indicated the resident was unable to perform management of medications.

The negotiated service agreement dated 10/25/13 documented the service of staff administration of medications.

The record contained an assessment by the operator/licensed nurse dated 12/12/12 of the resident's satisfactory ability to draw up the correct dose of insulin into a syringe and self-administer insulin. The record lacked an assessment when the resident experienced a significant change in condition or annually since the 12/12/12 assessment.

At 11:50 a.m. on 5/22/14, observed certified medication aide (CMA) #A assist resident to test blood sugar level with a glucometer with result of 142. CMA #A stated resident did not require insulin when blood sugar level was under 150. CMA #A stated that if resident's blood sugar was over 150, then resident drew up insulin into a syringe and self-administered insulin. Resident #452 confirmed he/she prepared insulin syringe and self-administered insulin when blood sugar level was over 150.

At 1:45 p.m. on 5/22/14, the operator/licensed nurse stated he/she did not assess the resident's ability to draw up and self-administer insulin at the time of the significant change functional capacity screen or annually.

The operator/licensed nurse failed to conduct an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3175	Continued From page 18 assessment of the resident #452's ability to prepare and self-administer insulin at least annually and when the resident experienced a significant change of condition.	S3175		
S3211 SS=F	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 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 27 residents. The sample included 3 residents. Based on interview and observation, for residents receiving over-the-counter medications, the operator/licensed nurse failed to ensure the licensed nurse or a licensed pharmacist placed the full name of the resident on the package. Findings included: - Review of the resident roster revealed the	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3211	Continued From page 19 facility performed medication management for 23 of the 27 residents. At 10:10 a.m. on 5/22/14, certified medication aide (CMA) #A stated CMAs placed the name of the resident on the over-the-counter medication when a family member brought the medication to the facility. CMA #A stated the facility also had over-the-counter "stock" medications for use if a resident ran out of their medication or the resident had a new order for the medication. At 10:45 a.m. on 5/22/14, operator/licensed nurse confirmed CMAs labeled over-the-counter medication containers with the resident's name when licensed nurse not in the facility. Operator/licensed nurse confirmed CMAs administered stock medications to residents from containers or packages not labeled by the licensed nurse or licensed pharmacist with the resident's name. At 3:00 p.m. on 5/22/14, CMA #B removed the following stock medications from a file cabinet: Ibuprofen (pain reliever) 200 milligrams (mg) tablets with 9 tablets remaining Acetaminophen (pain reliever) 500 mg tablets with approximately one-half of total tablets remaining. Acetaminophen 325 mg tablets, one unopened container and 3 opened containers. Docusate sodium (stool softener) 100 mg one opened bottle Loperamide (for treatment of diarrhea) 2 mg tablets, opened container Guaifenesin (to relieve chest congestion) 400 mg tablets, opened bottle Stomach Relief (stomach upset) liquid one full bottle and one bottle with one-third of contents remaining	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3211	Continued From page 20 Milk of Magnesia (laxative) opened bottle Tussin (to relieve chest congestion) liquid opened bottle and one unopened bottle Geri-Lanta (liquid antacid) 3 unopened bottles and one opened bottle. None of the above over-the-counter medication containers or packages contained the first and last name of a resident. For residents receiving administration of over-the-counter medications, the operator/licensed nurse failed to ensure the licensed nurse or a licensed pharmacist placed the full name of the resident on the package.	S3211		
S3214 SS=D	26-41-205 (g) (4) Sample & Indigent Medication Program Meds (g) (4) Licensed nurses and medication aides may administer sample medications and medications from indigent medication programs if the administrator or operator ensures the development of policies and implementation of procedures for receiving and identifying sample medications and medications from indigent medication programs that include all of the following conditions: (A) The medication is not a controlled medication. (B) A medical care provider ' s written order accompanies the medication, stating the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration. (C) A licensed nurse or medication aide receives the medication in its original, unbroken manufacturer ' s package. (D) A licensed nurse documents receipt of the medication by entering the resident ' s name and the medication name, strength, and quantity into	S3214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3214	Continued From page 21 a log. (E) A licensed nurse places identification information on the medication or package containing the medication that includes the medical care provider ' s name; the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider ' s order. Facility staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches the information on the medical care provider ' s order. (F) A licensed nurse informs the resident or the resident ' s legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies. The resident ' s clinical record shall contain documentation that the resident or the resident ' s legal representative has received the information and accepted the risk of potential adverse consequences. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(4)(A)(B)(C)(D)(E)(F) The facility reported a census of 27 residents. The sample included 3 residents. Based on interview and observation for 1 (#453) non-sampled resident, the operator/licensed nurse failed to implement the facility's policy and procedure for receiving and identifying the resident's sample medication as specified in the	S3214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3214	Continued From page 22 facility's written policy and procedure for receiving and identifying a sample medication as specified at KAR 26-41-205(g)(4)(A)(B)(C)(D)(E)(F). Findings included: - At 3:45 p.m. on 5/22/14, certified medication aide (CMA) #B stated only one resident received a sample medication. CMA #B removed a box of Pradaxa (blood thinning medication) 75 milligram tablets from the medication cart. Observed the name of resident #453 written on the box. CMA #B stated the resident had written his/her name on the medication package. The medication package lacked information written by the licensed nurse that included the medical care provider's name; the resident's name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider's order. At 1:15 p.m. on 5/27/14, the operator/licensed nurse provided the facility's sample medication policy and procedure dated 5/10/10 that contained all of the requirements specified at KAR 26-41-205(g)(4)(A)(B)(C)(D)(E)(F). Operator/licensed nurse stated he/she did not follow this policy and procedure for a sample medication. The operator/licensed nurse failed to implement the facility's policy and procedure for receiving and identifying resident #453's sample medication as specified in the facility's written policy and procedure for receiving and identifying a sample medication as specified at KAR 26-41-205(g)(4)(A)(B)(C)(D)(E)(F).	S3214		