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COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(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 the resurvey at the above named facility on 8-11-14, 8-12-14, 8-13-14, 8-18-14, 8-19-14 and 8-20-14.	S 000		
S3155 SS=F	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility identified a census of 18 Residents. The sample included 3 Residents. Based on record reviews, observations, and interviews for 3 (#100, #200, #300) of 3 Residents sampled, the operator failed to ensure a Licensed Nurse provided or coordinated the provisions of necessary Health Care Services (HCS) that meet the needs of each Resident and are in accordance with the Functional Capacity Screen (FCS) and the Negotiated Service Agreement (NSA). Resident #100 had 7 documented seizures, 3 emergency hospital admissions, experienced 2 falls with head injuries, dehydration, and diarrhea. Resident #200 experienced 4 seizures with one EMS transfer and admission to hospital and one fall with complaint of hip pain that required EMS transfer	S3155		

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

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to hospital. For Resident #300, the NSA/HCS lacked interventions for blindness, hard of hearing, insulin dependent diabetic, and Certified Staff to hand Resident a pre-filled insulin syringe to self-administer.

Findings included:

- Record review for Resident #100 revealed an admit date of 10-17-13 with diagnoses of Seizures, Recurrent Seizures, Dementia, Osteoarthritis, Hypertension, and Macular Degeneration.

The Functional Capacity screen (FCS) dated 10-8-13 (prior to admission) recorded Resident #100 independent with eating; required supervision with bathing, dressing, toileting, transfer, walking/mobility, bladder incontinence, communication, and facility staff managed medications/treatments. Resident #100 experienced impaired short term memory, memory recall, and decision making. Current or recent problems identified as impaired decision making, impaired vision, and wandering.

The negotiated service agreement/health care service plan (NSA/HCS) dated 10-17-13 recorded " Nursing services to be provided are as follows: "Medications will be administered by Certified Staff. Medications will be ordered and paid for by the Resident or Medicare. Bathing-shower two times per week with assist, morning preparation-assist, evening preparation-assist, personal hygiene-assist, ambulation/transfer independent, toileting-assist if needed, and walk to meals with stand by assist until oriented and able to do independently. "

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The NSA/HCS lacked interventions to address impaired cognition, impaired decision making and wandering.

The History and Physical dated 10-21-13 recorded past medical history: Seizure, Depression, Coronary Artery Disease, Recurrent Seizures, Pneumonia, Diabetic, Hypertension, and Alzheimer's Disease. Unable to fully assess due to dementia. Assessment Plan: Seizure disorder-no recent activity taking keppra (anti-seizure medication) and lamictal (anti-seizure medication).

The NSA/HCS lacked interventions to monitor for seizure activity.

The Medication administration record (MAR) recorded the following weights:

1-2014 -- 127.5 pounds (lbs)
2-1-14 -- 124.5 lbs
3-1-14 -- 121.5 lbs
4-1-14 -- 119.0 lbs
5-1-14 -- 118.0 lbs
6-1-14 -- 112.0 lbs
7-14-14 -- 111.5 lbs
8-1-14 -- 117.5 lbs

The NSA/HCS lacked interventions to address continued weight loss.

The nurses notes recorded the following:

12-2-13 at 2:00 p.m., "Resident is confused and lethargic. States just had a seizure. Upon assessment it was noted that Blood Pressure (B/P) was 80/41 and Pulse (P) 63. Resident complained of bad diarrhea. Physician notified

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lab complete blood count, keppra and lamictal levels, urine with culture and sensitivity. Resident drinking water in room." Licensed Nurse A.

The NSA/HCS lacked interventions to reduce risk of injury from seizures.

1-20-14 at 11:30 a.m., " Resident seen by ARNP for complaint of shoulder pain. New order for hydrocodone/acetaminophen 5/325 MG every four to six hours as needed for pain. " Licensed Nurse A.

2-3-14 at 1:00 p.m., " Resident seen by physician for shoulder pain. New order to administer norco every night at bedtime and apply bio freeze to both shoulders at bedtime as needed. " Licensed Nurse G.

The NSA/HCS lacked interventions to address residents ongoing shoulder pain

3-31-14 (no time) " Resident seen by ARNP. Resident had three pound weight loss in one month. Will check pre-albumin, weekly weights, and protein supplement two times a day. " Licensed Nurse A.

No further documentation in nurses notes until 5-19-14

5-19-14 (no time) Resident seen by ARNP. Resident complained of pain in back. Discontinue norco at bedtime. New order toradol (for pain) 50 MG orally at bedtime. " Licensed Nurse G.

6-2-14 at 10:40 a.m., " Resident seen by ARNP to discuss weight loss. Resident down five pounds this month. Will continue to encourage

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ensure twice a day and started on remeron 7.5 MG at bedtime for weight loss/anorexia. " Licensed Nurse A.

6-30-14 at 10:00, " Resident seen by ARNP for weight loss. Resident up four pounds this month. No order changes and continue to monitor. " Licensed Nurse A.

No further documentation in nurses notes until 7-22-14.

7-22-14 at 2:00 p.m., " Resident taken to neurology appointment by family. Resident found to be hypotensive at office appointment. Resident was sent to the hospital Emergency Room (ER) per neurologist for evaluation. ER admitted Resident for hypotension and renal insufficiency. " Licensed Nurse A.

The history and physical from the hospital dated 7-22-14 recorded Assessment and Plan:
1.) Acute renal failure presumably secondary to dehydration versus hypotension.
2.) Dehydration.
3.) History of seizures.
4.) Alzhemier ' s/Dementia.
5.) Hypotension has improved with intravenous fluids.
6.) Hypertension.
7.) Reports of diarrhea ongoing for one month ' s time and seems more chronic in nature.

7-24-14 at 6:00 p.m., " Resident has returned to facility by family. Resident has multiple medication dosage changes. Note sent to neurologist and physician to please advise of correct medication regimen. " Licensed Nurse A.

The NSA/HCS lacked interventions to address

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hydration and diarrhea.

7-25-14 at 8:45 a.m., " Resident fell out of bed; possible seizure. Bruising to left side of face. No apparent injury with bruising. Physician and family informed. " Licensed Nurse A.

7-25-14 at 12:00 p.m., " Resident had small petit mal seizures times two. Resident being watched closely. " Licensed Nurse A.

7-25-14 at 2:00 p.m., " Resident ' s family member at bedside. . . . At this time Resident had a grand mal seizure lasting greater than one minute. Physician informed and instructed me to activate EMS and Resident was returned to the hospital for evaluation. " Licensed Nurse A.

7-25-14 at 3:10 p.m., " Resident on cot and left via EMS en route to hospital ER. Report called to ER nurse, neurology paged and informed of Resident ' s change in condition and transfer. " Licensed Nurse A.

7-28-14 at 6:00 p.m., " Resident was discharged back to facility from hospital. Resident had vimpat (seizure medication) added and some changes to all seizure medications. The neurologist called to give personal report. Resident at baseline and talking with staff. " Licensed Nurse A.

7-28-14 at 7:00 p.m., " Resident walked into kitchen without walker. Staff went to assist Resident. Resident unclear with speech. Staff assisted Resident to floor and Resident again had a grand mal seizure. Staff kept Resident injury free. Resident started speaking after approximately 45 seconds. Resident assisted to

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recliner and staff remained one on one with Resident. Physician, neurologist and family informed. Neurologist said to make sure Resident received bedtime vimpat and to call if any further changes. Resident remained seizure free the rest of the shift. " Licensed Nurse A.

7-29-14 at 10:30 p.m., " Resident is currently asleep in bed. Resident had a good day and ate well. No seizure activity and interactive with staff and peers. Resident at his/her baseline. No increase in sleepiness. Ensure held due to Resident having loose stools previous day. " Signed Licensed Nurse A.
The NSA/HCS lack interventions to address monitoring for seizures, reduction of risk of injury from seizures, and management of diarrhea.

8-1-14 at 5:00 p.m., " Received a call from Licensed Nurse G that Resident was transferred via EMS to hospital ER for evaluation related to fall versus seizure activity in his/her room in which he/she fell and hit head. " Licensed Nurse A.

No further documentation in record through 8-14-14.

Interview on 8-12-14 at 1:35 p.m. with Licensed Nurse A stated, " Resident weighed 131 pounds (LBS) in December 2013 and unable to locate an admit weight. Licensed Nurse A further stated, " did not see any issues with diarrhea. Resident had diarrhea two times and informed staff to hold the ensure protein drink. He/she did not address in HCS because it was not a problem. " The Licensed Nurse also stated He/she " did not address seizures, weight loss, or signs/symptoms dehydration in the FCS/NSA/HCS nor did he/she do a significant change in condition. "

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S3155	Continued From page 7 Interview on 8-12-14 at 11:00 a.m. with Certified Staff E stated and confirmed, " (Resident #100) did not have a care plan for seizures, signs and symptoms of dehydration, and diarrhea. " Confidential Interview on 8-12-14 at 10:00 a.m. stated, " (Resident #100) had diarrhea for days along with several seizures. Informed (Licensed Nurse G) of diarrhea and weight loss. Resident went to hospital with seizures, came back to facility and had seizures and then sent back to hospital with seizures. (Resident) had a physician appointment on 7-22-14. At doctor appointment weight was 111 pounds. After getting weighed (Resident) turned grey and nurse sat (Resident) in chair and yelled for the physician. The physician came in and ordered staff to take Resident across to the ER. While (Resident) in the ER he/she had a seizure and was admitted to hospital for severe dehydration, diarrhea, and seizures. On 7-24-14 Resident was discharged back to facility with new orders. When Resident had fall on 7-25-14 at 8:45 a.m. was notified of fall and informed of slight bruise to face. Was not informed of the two (petit mal) seizures. Stated (Resident ' s) face was swollen, eyes swollen, whole face bruised, purple, black and blue around eyes, face, down neck and right shoulder going down arm. Resident still has bruising from that fall. When Resident went to the hospital on 8-1-14 he/she had a knot/hematoma the size of a baseball on back of his/her head and still has a knot/bruised on back of head. Resident did not get medications as ordered nor was the (Licensed Nurses) doing anything about diarrhea, weight loss, and felt he/she had more seizures than identified because staff not monitoring close enough. Resident is now in a skilled rehab center and doing well. "	S3155		

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For Resident #100 who experienced 7 documented seizures, 3 emergency hospital admissions, experienced 2 falls with head injuries, dehydration, and diarrhea, the operator failed to ensure the licensed nurse provided or coordinated the provisions of necessary Health Care Services (HCS) that meet the needs of the Resident .

- Record review for Resident #200 revealed an admit date of 5-15-14 with diagnoses of Seizures, Chronic Obstructive Pulmonary Disease, Hypertension, Schizophrenia and Sleep Apnea.

The FCS dated 5-15-14 recorded Resident required supervision with bathing dressing, toileting, transfer, walking/mobility, eating, communication, facility staff to administer medications/treatments, experienced short term memory loss, memory recall, decision making, Current or recent problems documented as impaired decision making, impaired vision, and falls/unsteadiness.

The NSA/HCS dated 5-14-14 recorded " Nursing services to be provided are as follows: "Medications will be administered by Certified Staff. Medications will be ordered and paid for by the Resident or Medicare. Bathing-shower two times per week with assist, morning preparation-assist, evening preparation-assist, personal hygiene-assist, ambulation/transfer independent, toileting-assist if needed, and briefs supplied by (facility) and paid for by Resident, walk to meals with stand by assist until oriented and able to do independently. "

The NSA/HCS lacked interventions to address Resident #200 ' s impaired cognition and falls and

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unsteadiness.

The nurses notes recorded:

6-26-14 at 7:50 a.m., " Resident was lying in hall by medications cart. Resident was reported to be having a seizure. Resident alert again in a matter of seconds. Resident placed in recliner in main living area so staff could observe continually. Blood Pressure (B/P) 90/66, Pulse (P) 70, Respirations (R) 20. Resident sleeping but easily responds to verbal stimuli. " Licensed Nurse A.

6-26-14 at 10:30 a.m., " Resident remains on visual checks. No seizure activity noted. Resident alert and at baseline. " Licensed Nurse A.

6-26-14 at 12:50 p.m., " Resident lying in bed in room and had a second seizure. Resident very sleepy but responsive to verbal stimuli. Resident had frothy sputum. No loss of bowel or bladder. Resident is on Depakote (seizure medication) three times a day with recent lab obtained a month ago and in therapeutic levels. Physician notified. Transport Resident to hospital via EMS for evaluation. Family notified. " Licensed Nurse A.

6-29-14 4:00 p.m., " Resident has been discharged from the hospital and returned to facility. Medications remained the same. " Licensed Nurse A.

The NSA/HCS lacked interventions to address monitoring for seizure activity and interventions to reduce risk of injury from seizures.

No further documentation in nurses notes until 7-12-14.

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S3155	Continued From page 10 7-12-14 at 2:45 p.m., " Received a call that Resident had fell in bathroom. Resident was complaining of hip pain and that he/she hit head. Staff unable to move Resident without pain so was transferred to hospital by EMS for evaluation. Family and physician notified. " Licensed Nurse A. 7-15-14 at 3:30 p.m., " Staff reports Resident had two small seizures. Upon arriving at facility Resident was able to wake up and sit on side of bed. Resident coherent and stated did not fall and do not want to go to the hospital. Possible seizure activity reported to ARNP and family. Will continue with close monitoring. " Licensed Nurse A. 7-16-14 at 4:00 p.m., " Resident at baseline. Very active today without any seizure activity. Licensed Nurse. A. Interview on 8-12-14 at 3:35 p.m. with Licensed Nurse A stated and confirmed the NSA/HCS lacked interventions for falls/unsteadiness, seizures, and impaired cognition. 8-12-14 at 5:00 p.m., observed Resident eating in the dining room. Stated liked the food served here. Interview on 8-12-14 at 5:10 p.m. with Resident #200 stated, takes own shower and staff turns water on for him/her. Further stated, did have some seizures since living here but doing better now. Resident stated wears a C-Pap breathing machine at night. Ambulates with a walker in the hallway. The NSA/HCS lacked documentation of	S3155		

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management of Resident ' #200 ' s C-Pap at night.

Resident #200 experienced 4 seizures with one EMS transfer and admission to hospital and one fall with complaint of hip pain that required EMS transfer to hospital. The NSA/HCS lacked interventions for seizures and falls/unsteadiness.

- Record review for Resident #300 revealed an admit date of 7-27-12 with diagnoses of Insulin Dependent Diabetes, Complete Blindness, Renal Failure, Hypertension, Coronary Artery Disease and Anemia.

The FCS dated 7-29-13 and 7-29-14 recorded Resident independent with toileting, transfer, bladder incontinence, cognition, communication, and no falls/unsteadiness.

The NSA/HCS dated 7-29-14 " Nursing services to be provided are as follows: "Medications will be administered by Certified Staff. Medications will be ordered and paid for by the Resident or Medicare. Bathing-shower two times per week with assist, morning preparation-assist, evening preparation-assist, personal hygiene-assist, ambulation/transfer independent, toileting-assist if needed, and briefs supplied by (facility) and paid for by Resident, walk to meals with stand by assist until oriented and able to do independently. "

Interview on 8-13-14 10:30 a.m. with operator stated and confirmed the NSA/HCS lacked interventions for complete blindness, hard of hearing, and insulin dependent diabetic. The NSA/HCS lacked instructions for Certified Staff to hand prefilled insulin syringe to Resident to self-administer.

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S3155	Continued From page 12 Interview on 8-13-14 at 11:20 a.m. with Licensed Nurse A stated and confirmed the NSA/HCS lacked interventions for blindness, hard of hearing, insulin dependent diabetic, and Certified Staff to hand Resident prefilled insulin syringe to self-administer. Interview on 8-13-14 at 11:25 a.m. with Resident #300 stated had been an insulin dependent diabetic since 1989 and lost vision in 2012, now totally blind. Resident came to this facility and can self-administer pre-filled insulin syringes and unable to identify when blood sugar high or low. For Resident #300, the NSA/HCS lacked interventions for blindness, hard of hearing, insulin dependent diabetic, and Certified Staff to hand Resident a pre-filled insulin syringe to self-administer. For Residents #100, #200, #300, the operator failed to ensure a Licensed Nurse provided or coordinated the provisions of necessary HCS that meet the needs of each Resident and are in accordance with the FCS and the NSA.	S3155		
S3200 SS=F	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the 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	S3200		

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(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
S3200	Continued From page 13 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: KAR 26-41-205(d) The facility identified a census of 18 Residents. The sample included 3 Residents. Based on record review, interview and observation for 2 (#100, #200) 3 Residents sampled, the operator failed to ensure that all medications administered in accordance with a medical provider's written order and professional standards of practice. Findings included: - Record review for Resident #100 revealed an admit date of 10-17-13 with diagnoses of Seizures, Recurrent Seizures, Dementia, Osteoarthritis, Hypertension, and Macular Degeneration. The FCS dated 10-8-13 (prior to admission) recorded Resident #100 required facility staff managed medications/treatments. The NSA/HCS dated 10-17-13 "Medications will be administered by Certified Staff. Medications will be ordered .. .Quarterly pharmacy reviews will be conducted and paid for by (facility).	S3200		

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S3200	Continued From page 14 Review of the record revealed the following medications not administered as ordered On 12-9-13 at 11:15 a.m., the Advanced Registered Nurse Practioner (ARNP) ordered Ambien 5 Milligrams (MG) at hour of sleep (sleeping pill). The Medication Administration Record (MAR) recorded on ambien was not administered due to not available on 2-21-14, 4-23-14, 4-24-14, 4-25-14 and 4-26-14. On the 4-1-14 MAR recorded Exelon patch 13.3 MG (for dementia) apply daily was not available from pharmacy or administered on 4-22-14, 4-23-14, 4-25-24, 4-26-14, 4-27-14, and 4-28-14. The Resident left the facility at 2:00 p.m. on 7-22-14 and was admitted to hospital. The Resident returned from the hospital on 7-24-14 at 6:00 p.m. The physician orders from hospital dated 7-24-14 ordered Keppra 500 MG every eight hours (for seizures) and Lamictal 100 MG two times a day (for seizures.) The MAR documented the following discrepancies: 7-24-14: The MAR lacked documentation that either Keppra 500 MG or Lamictal 100 MG were administered as ordered 7-25-14: The MAR recorded Keppra 250 MG administered at 8:00 a.m. (not 500 MG as ordered) and Lamictal 100 MG administered at 8:00 a.m. The MAR lacked administration of additional doses of either medication administered. The record documents Resident #100	S3200		

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S3200	Continued From page 15	S3200		

experienced 4 seizures on 7-25-14 and was transferred to the hospital at 3:10 p.m. The nurses notes documented the following:
7-25-14 at 8:45 a.m., " Resident fell out of bed; possible seizure. Bruising to left side of face. No apparent injury with bruising. Physician and family informed. " Licensed Nurse A.

7-25-14 at 12:00 p.m., " Resident had small petit mal seizures times two. Resident being watched closely. " Licensed Nurse A.

7-25-14 at 2:00 p.m., " Resident ' s family member at bedside. . . . At this time Resident had a grand mal seizure lasting greater than one minute. Physician informed and instructed me to activate EMS and Resident was returned to the hospital for evaluation. " Licensed Nurse A.

On 7-28-14 at 6:00 p.m. Resident readmitted to facility from the hospital. Resident had orders for Vimpat 50 MG every 12 hours (for seizures), Keppra 500 MG every eight hours, and Lamictal 200 MG twice a day. The Nurses notes recorded on 7-28-14 at 7:00 p.m. Resident #100 had a grand mal seizure. The neurologist was notified wanted to make sure Resident received the HS (9:00 p.m.) Vimpat 50 MG.

Review of the MAR documented the following discrepancies:
7-28-14: MAR documented Lamictal 100 mg administered at 5 p.m. (order for 200 MG and nurses note documents resident did not return to facility until 6 p.m.) The MAR lacked documentation of administration of Keppra or Vimpat as ordered

Confidential interview on 8-12-14 at 10:00 a.m. stated the (Licensed Nurse) did not follow doctor

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orders when (Resident) returned from the hospital on 7-24-14. On 7-24-14 Resident was discharged back to facility with new orders. When Resident had fall on 7-25-14 at 8:45 a.m. was notified of fall and informed of slight bruise to face. Was not informed of the two (petit mal) seizures. Stated (Resident ' s) face was swollen, eyes swollen, whole face bruised, purple, black and blue around eyes, face, down neck and right shoulder going down arm. Resident still has bruising from that fall.

Interview on 8-12-14 with Licensed Nurse A at 2:35 p.m. stated and confirmed medications not administered as ordered by the physician. Licensed Nurse A also stated he/she was not aware of Exelon patches and ambien not available to administer per physician orders.

Interview on 8-13-14 at 9:20 a.m. with Certified Staff E stated if a medication is not available will circle medication and write on back why medication was not administered and then would tell the Licensed Nurse.

For Resident #100, the Operator failed to ensure medications administered as per physician ' s order. Facility staff failed to administered medication to treat seizures according to physician orders on 7-24-14 and 7-25-14 and Resident #100 experienced four seizures and required hospitalization.

- Record review for Resident #200 revealed an admit date of 5-15-14 with diagnoses of Seizures, Chronic Obstructive Pulmonary Disease, Hypertension, Schizophrenia and Sleep Apnea.

The FCS dated 5-15-14 recorded Resident required facility staff to administer

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medications/treatments.

The NSA/HCS dated 5-14-14 recorded "Medications will be administered by Certified Staff. Medications will be ordered . . . Quarterly pharmacy reviews will be conducted and paid for by (facility). "

Review of the Medication Administration Record (MAR) revealed the following discrepancies:

Folic Acid 1 Milligram (MG) (vitamin) one tablet daily ordered on 5-15-14. The MAR dated 7-17-14, 7-18-14, 7-19-14, 7-20-14, 7-21-14 and 7-22-14 recorded the medication was not administered due to waiting on pharmacy.

New order for Folic Acid 2 MG daily ordered on 7-27-14 not documented as administered until 7-29-14.
Vitamin B-12 1000 every day ordered on 7-27-14 not documented as administered until 7-29-14.

Vimpat 100 MG ½ tablet 50 MG daily at noon (for seizures). The MAR lacked documentation of administration on 8-4-14, 8-5-14, 8-7-14, 8-10-14 and 8-12-14.

New order for Gabapentin 300 MG two times a day ordered 7-25-14

The MAR also recorded Gabapentin three times daily (for neuropathy) at 8:00 a.m., 12:00 noon, and 8:00 p.m. as administered on 8-1-14, 8-2-14, 8-3-14 and 8 a.m. on 8-4-14 The MAR also recorded Gabapentin 300 MG two times a day at 8:00 a.m. and 8:00 p.m. as administered 8-1-14 through 8-12-14

Interview on 8-12-14 at 3:50 p.m. with Licensed

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S3200	Continued From page 18 Nurse A stated and confirmed Folic Acid, Gabapentin, Vimpat and Vitamin B-12 not administered as ordered by physician. Interview on 8-12-14 at 4:45 p.m. with Operator stated was not aware medications not available. For Resident #200, the Operator failed to ensure medications administered per written physician orders. For 2 (#100, #200) of 3 residents sampled, the operator failed to ensure that all medications were administered in accordance with a medical care provider ' s written order and professional standards of practice.	S3200		
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.	S3280		

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S3280	Continued From page 19 This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility identifed a census of 18 Residents. The sample included 3 Residents. Based on record review and interview for all employees, the operator failed to ensure a quarterly review of the facility's emergency management plan with employees. Findings included: - Review of the emergency management plan lacked a quarterly review for employees. Interview on 8-11-14 at 4:00 p.m. with operator stated was not able to locate quarterly reviews for staff. For all employees, the operator failed to ensure a quarterly review of the facility's emergency management plan.	S3280		
S3320 SS=F	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and	S3320		

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S3320	Continued From page 20 equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 26-41-254(a) The facility identified a census of 18 Residents. The sample included 3 Residents. Based on observations and interview for all Residents, the operator failed to ensure the facility maintained to protect the health and safety of Residents, personnel and the public. Findings included: - During tour of facility on 8-11-14 at 2:15 p.m. with the operator, observed the back exit door to parking lot partially open approximately three inches. The operator then opened the exit door and surveyor observed the bottom base of metal door frame rusted and coming loose from the door frame. At the base of the door frame observed sand/dirt underneath the door in entry way. The operator and I went out the door as he/she was trying to close the door. The operator pushed the door hard a couple of times to get it closed. After door was closed, the operator was unable to get door open. The operator went into facility at another exit and came and opened the exit door. The operator stated he/she would call	S3320		

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S3320	Continued From page 21 and get the door/door frame fixed. The operator failed to ensure the facility maintained to protect the health and safety of Residents, personnel and the public.	S3320		