STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063012	A. BUILDING: _____ B. WING _____	02/27/2019

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ASBURY VILLAGE	3800 ASBURY DRIVE COFFEYVILLE, KS 67337

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 2/25/19, 2/26/19 and 2/27/19.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a) (3) The facility reported a census of 15 residents. The sample included 3 residents. Based on interview and record review the operator failed to ensure the negotiated service agreement provided identification of each party responsible for payment of outside services for 2 of 3 residents sampled (#281 and #311).	S3085		

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

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S3085	Continued From page 1 Findings included: - Record review for resident #281 revealed an admission date of 9/26/18 with diagnoses of hypertension, depression, constipation, anxiety and pain. Licensed nurse/operator B indicated the resident had a hospital stay on 2/17/19 and returned 2/19/19 on Hospice services. The significant change functional capacity screen dated 2/21/19 identified the resident with intact cognition, needed physical assistance with bathing and supervision for dressing, toileting, transfers and ambulation. He/she had elected to receive Hospice services. The negotiated service agreement (NSA) dated 2/21/19 directed staff to assist the resident with bathing and personal care needs as requested. The resident at times will need 1 staff assistance to transfers due to weakness and shortness of breath. On 2/19/19 the resident admitted to Hospice services. The NSA failed to indicate the responsible party for payment of the outside provider for Hospice services. Interview on 2/26/19 at 11:14 AM with licensed nurse/operator B confirmed the resident received Hospice services and the NSA lacked the payor information for the services. The operator failed to ensure the negotiated service agreement provided identification of each party responsible for payment of outside services for this resident receiving Hospice services. - Record review for resident #311 revealed an	S3085		

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S3085	Continued From page 2 admission date of 11/3/17 with diagnoses of stroke, urinary retention, valvular insufficiency, depression, glaucoma, hypothyroidism, hypertension, reflux and constipation. The annual function capacity screen dated 10/1/18 identified the resident with intact cognition, needed physical assistance with bathing, dressing and medication/treatment management. He/she needed supervision with transfers and ambulation, used a wheelchair for mobility and at risk for falls/unsteadiness. The negotiated service agreement (NSA) dated 10/1/18 directed staff to provide assistance with bathing, dressing and the resident would call for assistance if needed with toileting. He/she used a wheelchair and could self-propel in the common areas. The NSA was revised on 1/17/19 with resident began physical therapy per resident choice. The NSA failed to indicate the responsible party for payment of the outside provider for the physical therapy. Record review revealed a note for physical therapy re-evaluation dated 2/15/19 which indicated the resident would continue to receive services 3 times a week for 4 weeks. Interview on 2/26/19 at 11:14 AM with licensed nurse/operator B confirmed the resident received physical therapy services and the NSA lacked the payor information for the services. The operator failed to ensure the negotiated service agreement provided identification of each party responsible for payment of outside services for this resident receiving physical therapy services.	S3085		

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S3200	Continued From page 3	S3200		
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 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: KAR 26-41-205 (d) The facility reported a census of 15 residents. The sample included 3 residents. The facility identified 13 residents received medication management by the facility. Based on interview and record review the operator failed to ensure 1 of 3 sampled (#311) resident's medications and biologicals were administered in accordance with a medical care provider's written orders and professional standards of practice regarding consultation with a nurse before administration of PRN (as needed) medications by certified medication aides.	S3200		

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S3200	Continued From page 4 Findings included: - The resident roster provided on 2/25/19 at 1:00 PM included 13 residents identified with facility management of medications. Record review for resident #311 revealed an admission date of 11/3/17 with diagnoses of stroke, urinary retention, valvular insufficiency, depression, glaucoma, hypothyroidism, hypertension, reflux and constipation. The annual function capacity screen dated 10/1/18 identified the resident with intact cognition, needed physical assistance with bathing, dressing and medication/treatment management. The negotiated service agreement/health service plan (NSA/HSP) dated 10/1/18 directed certified medication aides (CMAs) or licensed nurses will administer the resident's medications. The recapitulation of the physician's orders signed 2/4/19 revealed an order for Tylenol 325 milligrams 2 tablets by mouth every 4-6 hours PRN (as needed), not to exceed more than 3 grams in a 24-hour period. The order did not identify the reason for use. Review of the February 2019 medication administration record (MAR) revealed the resident received the PRN Tylenol by CMAs as follows: 2/01/19 at 12:21 AM for back pain 2/01/19 at 8:08 PM for pain 2/02/19 at 8:58 AM for back pain 2/03/19 at 2:20 AM for pain 2/03/19 at 12:39 PM for back pain	S3200		

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S3200	Continued From page 5 2/03/19 at 8:56 PM for pain 2/04/19 at 10:08 AM for pain 2/04/19 at 4:38 PM for back pain 2/11/19 at 9:41 PM for back pain 2/12/19 at 7:47 AM for pain 2/14/19 at 10:42 AM for pain 2/14/19 at 8:04 PM for pain 2/16/19 at 11:57 PM for pain None of the above documentation included any evidence the nurse was consulted before administration of the PRN Tylenol without a specific reason written from the medical provider. Review of the nursing notes revealed entry dated 1/21/19 at 2:30 PM with the next note dated 2/11/19 at 5:30 PM about a physician's appointment and no information about pain or consult with a nurse about pain. The next note dated 2/12/19 at 6:00 PM regarding a physician appointment and no information about pain or consult with the nurse. The next note dated 2/20/19 at 12:30 PM continued on physical therapy services... Interview on 2/26/19 at 9:15 AM with CMA C revealed the routine practice for PRN administration included verifying the resident had an order for what the resident requested. If the resident had an order, then he/she would give the medication but if the resident did not have an order he/she would call the nurse. He/she indicated some residents have specific directions to call the nurse before giving a certain PRN medication. He/she identified resident #311 needed nurse approval before a PRN laxative was administered. He/she basically can give all the residents the PRNs the residents have ordered without contacting the nurse. Interview on 2/26/19 at 9:30 AM with licensed	S3200		

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S3200	Continued From page 6 nurse/operator B confirmed the CMAs can give PRN medications if the resident has an order for the medication. He/she said the staff call him/her frequently about resident(s) illness, reports of pain or discomfort or medical needs. He/she confirmed the resident's record did not reflect being consulted before administration of PRN medications. He/she confirmed the Tylenol order did not include an indication for use. The operator failed to ensure this resident medications and biologicals were administered in accordance with a medical care provider's written orders and professional standards of practice regarding consultation with a nurse before administration of PRN medications by certified medication aides.	S3200		
S3211 SS=E	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:	S3211		

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S3211	Continued From page 7 KAR 26-41-205 (g) (3) The facility reported a census of 15 residents. The facility identified 13 residents received medication management by the facility. Based on observation, interview and record review the operator failed to ensure a licensed nurse or licensed pharmacist labeled over-the-counter (OTC) medications with the resident's full name on both the original manufacturer's medication package and the medication container. Findings included: - The resident roster provided on 2/25/19 at 1:00 PM included 13 residents identified with facility management of medications. On 2/25/19 at 12:45 PM certified medication aide (CMA) A opened the medication cart located within the medication storage room and identified the cart as the only medication cart. Observation revealed the medication cart contained multiple bottles/containers of over-the-counter (OTC) medications used by residents. The OTC bottles/containers lacked labeling with the resident's full name as follows: Resident #273 had 2 OTC medications with just the first initial and last name or last name only Resident #311 had 3 OTC medications with just the first initial and last name or had the full name on the box but nothing on the container which could be separated from the box. Resident #281 had 1 OTC labeled with first initial and last name Resident #407 had 2 OTC labeled with first initial and last name Resident #416 had 2 OTC with the box labeled but not the container which could be separated from the box.	S3211		

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S3211	Continued From page 8 Resident #323 and #324 had 3 OTC bottles labeled for both to use. The bottle of Clear-lax labeled with last name and room number when compared to the physician's orders revealed no order for resident #324. The cart contained 1 unopened and unlabeled bottle of Milk of Magnesia which CMA A identified as a back-up bottle for resident #422. Interview on 2/25/19 at 12:45 PM with CMA A revealed he/she would write the resident's name or room number and the date opened on all OTC medications. Interview on 2/25/19 at 12:45 PM with licensed nurse/operator B confirmed the CMAs were writing the residents' name and room number when the CMA opened the bottle. He/she was not aware the regulation required the full name and to be labeled by a licensed nurse or licensed pharmacist. On 2/26/19 at 9:55 AM he/she confirmed resident #324 did not have an order for the Clear-lax which the container was labeled for resident #323 and #324. The operator failed to ensure a licensed nurse or licensed pharmacist labeled over-the-counter (OTC) medications with the resident's full name on both the original manufacturer's medication package and the medication container.	S3211		
S3255 SS=F	26-41-105 (b) Resident Records Confidential (b) Each administrator or operator shall ensure that all information in each resident's record, regardless of the form or storage method for the record, is kept confidential, unless release is required by any of the following: (1) Transfer of the resident to another health care	S3255		

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S3255	Continued From page 9	S3255		

facility;
(2) law;
(3) third-party payment contract; or
(4) the resident or legal representative of the resident.
KAR 26-41-105 (b)

The facility reported a census of 15 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to ensure that all residents' information was kept confidential.

Findings included:

- On 2/25/19 at 11:45 AM licensed nurse/operator B reported the facility emergency management plan and resident council minutes were in the lobby/TV area on the entertainment center.

Observation on 2/25/19 at 12:20 PM revealed a dark pink/red colored 3-ring notebook labeled emergency preparedness located on the shelf next to the video/DVD player. Along with this notebook was a white notebook labeled resident council minutes.

Record review revealed within the emergency preparedness notebook in a sheet protector was a multiple page resident roster which included 18 residents' names and Y (yes) N (no) under the columns of gives own meds, insulin injection, bed rails, uses incontinent products, catheter, 2 person transfers, fall in last 180 days, outside provider, assistance to toilet, assistance to bath, impaired cognitive status, skin problem and special treatment dated 1/20/13.

The resident council notebook under the March

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S3255	Continued From page 10 tab was a document from 3/8/18 regarding an Ombudsman visit and presentation. Attached to this information was a resident roster which included 19 residents' names and Y (yes) N (no) under the columns of gives own meds, insulin injection, bed rails, uses incontinent products, catheter, 2-person transfers, fall in last 180 days, outside provider, assistance to toilet, assistance to bath, impaired cognitive status, skin problem and special treatment dated 1/20/13. Interview on 2/25/19 at 12:23 PM with licensed nurse/operator B confirmed the residents' personal and confidential information contained on the resident roster should not be in the public setting of the emergency preparedness and resident council notebooks located in the common area and available for the public. The operator failed to ensure that all residents information was kept confidential.	S3255		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105 (f)(11) The facility reported a census of 15 residents. The sample included 3 residents. Based on	S3261		

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S3261	Continued From page 11	S3261		

observation, interview and record review the operator failed to ensure the documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action taken and results of the action for 1 of 3 sampled residents (#281).

Findings included:

- Record review for resident #281 revealed an admission date of 9/26/18 with diagnoses of hypertension, depression, constipation, anxiety and pain.

The significant change functional capacity screen dated 2/21/19 identified the resident with intact cognition, needed physical assistance with bathing and supervision for dressing, toileting, transfers and ambulation. He/she had elected to receive Hospice services.

The negotiated service agreement (NSA) dated 2/21/19 directed staff to assist the resident with bathing and personal care needs as requested. The resident at times will need 1 staff assistance to transfers due to weakness and shortness of breath. On 2/19/19 the resident admitted to Hospice services.

Review of the physician orders revealed a fax communication to the physician which read "making you aware that resident was discharged from [hospital] today post MI (myocardial infarction). Resident has decided to return to [facility] with hospice order in place"

Review of the nursing notes revealed the last entry was dated 1/29/19 at 9:20 AM regarding resident concerns about constipation and communication by fax with the physician about

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S3261	Continued From page 12 the resident's concern. Interview on 2/26/19 at 11:14 AM with licensed nurse/operator B revealed the resident saw the physician on 1/29/19 for EKG. On 2/11/19 the resident saw the physician and was diagnosed with costochondritis and treated with an anti-inflammatory and topical medication. On 2/15/19 a fax communication was sent to the physician regarding left ankle swelling and later that evening licensed nurse B received a call back with orders to stop the anti-inflammatory, use Tylenol instead, elevate the resident's feet and call Monday (2/18/19) to make an appointment. On 2/17/19 staff called licensed nurse B and reported the resident was not feeling well, doubled over in pain and having trouble breathing. Nurse B directed staff to call emergency medical services (EMS) and the resident transferred by EMS to local emergency department. Licensed nurse B said the resident was then transported to another hospital and admitted. The resident returned to the facility on 2/19/19. Licensed nurse B confirmed the resident's record lacked all the above information. The operator failed to ensure the documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action taken and results of the action for this resident regarding an illness which required EMS, hospital admission and readmission to the facility.	S3261		