STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with a complaint (#115517, #131081, #131083) at the above named assisted living facility conducted on 7/24,25,26/2018.	S 000		
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. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a)(1)(2) The facility reported a census of 26 residents. The sample included 3 residents and 1 focused review. Based on record review and interview for all residents, the Administrator failed to ensure that designated facility staff completed the Negotiated Service Agreement to include a description of the outside services the resident	S3085		

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

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S3085	Continued From page 1	S3085		

received and identification of the provider of each service for 3 (#101, #102,#103) of 3 residents.

Findings included:

- Review of resident #101's record revealed he/she admitted to the facility on 6/1/17 with diagnosis of diabetes type II, thyroid disease and hypertension.

Review of the functional capacity screen dated 5/30/18 revealed the resident required physical assistance with bathing and assistance with medications.

Review of the negotiated service agreement (NSA) dated 5/30/18 revealed the resident received the services from the following outside providers: laboratory, podiatry, therapy, pharmacy, and beauty shop. The NSA lacked what type of therapy services the resident received and who provided the therapy and pharmacy services.

- Review of resident #102's record revealed he/she admitted to the facility on 7/13/18 with diagnoses of syncope, hypertension, and chronic atrial fibrilation.

Review of the functional capacity screen dated 7/13/18 the resident needed physical assistance with bathing and administration of medications.

Review of the negotiated service agreement (NSA) dated 7/13/18 revealed the resident received the following services from an outside provider: laboratory, podiatry, therapy, pharmacy, home health, and beauty shop. The NSA lacked what type of therapy service the resident received and who provided the therapy, home health and

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S3085	Continued From page 2	S3085		

pharmacy services.

- Review of resident #103's record revealed he/she admitted to the facility on 5/31/11 with diagnosis of hypertension, pain, osteoporosis, and dementia.

Review of the functional capacity screen dated 5/7/18 revealed the resident needed physical assistance with bathing, administration of medications and was at risk for falls.

Review of the negotiated service agreement (NSA) dated 5/7/18 revealed the resident received the following services from an outside provider: laboratory, podiatry, pharmacy and beauty shop services. The NSA lacked information regarding who provided pharmacy services.

During an interview on 7/25/18 at 3:42 PM administrative nursing staff A reported he/she did not realize the service agreement needed to include the specific name of the outside provider.

Review of the undated negotiated service agreement policy revealed the negotiated service agreement would provide the following information: description of the services the elder will receive and the provider of each service.

The administrator failed to ensure designated staff included a description of the outside services the resident received and identification of the provider of each service for 3 (#101, #102,#103) of 3 residents, which also had the potential to affect all residents who received outside services.

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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 26 residents. The sample included 3 residents and 1 focused review. Based on interview and record review the administrator failed to ensure certified staff administered medications according to standards of practice for 2 (#101,#103) of 3 residents. Findings included: - Review of resident #101's record revealed he/she admitted to the facility on 6/1/17 with diagnosis of diabetes type II, thyroid disease and hypertension.	S3200		

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S3200	Continued From page 4 Review of the functional capacity screen dated 5/30/18 revealed the resident required assistance with management of medical treatments. Review of the negotiated service agreement (NSA) dated 5/30/18 revealed certified staff administered the residents oral medications and he/she self administered his/her insulin. Review of the signed physicians order sheet dated 6/25/18 included an order for Tamsulosin HCL 0.4 mg. 1 capsule after noon meal. Review of the July 2018 medication administration record revealed certified staff B circled his/her initials on 7/8,10/18 and documented he/she did not administer the medication due to not being available. Review of the nurses notes lacked evidence staff notified the nurse or physician the medication was not available to administer. During an interview on 7/25/18 at 4:18 PM certified staff C reported if a medication was not available he/she needed to circle it and document not available. He/she then needed to contact the pharmacy and tell the nurse why it was not administered. During an interview on 7/25/18 at 3:45 PM administrative nursing staff A reported if a medication is not available certified staff need to let the nurse know so he/she could contact the pharmacy. The administrator failed to ensure staff followed standards of practice for when medications are not available for administration from the	S3200		

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S3200	Continued From page 5 pharmacy. - Review of resident #103's record revealed he/she admitted to the facility on 5/31/11 with diagnosis of hypertension, pain, osteoporosis, and dementia. Review of the functional capacity screen dated 5/7/18 revealed the resident could not administer his/her own medications. Review of the negotiated service agreement (NSA) dated 5/7/18 revealed staff administered the residents medications to him/her. Review of the signed physicians order sheet dated 6/22/18 revealed an order for Tylenol 325 mg 2 tablets every 8 hours as needed for pain. (did not specify what type of pain) Review of the May 2018 medication administration record (MAR) revealed the certified staff initialed administration of Tylenol 9 times and lacked follow-up assessment by licensed nursing staff. The MAR revealed 6 times the certified staff documents assessment of the effectiveness of the medication. Review of the June 2018 MAR revealed certified staff administered Tylenol 4 times and lacked follow-up assessment by licensed nursing staff. Review of the July 2018 MAR revealed certified staff administered Tylenol 6 times without follow-up assessment by licensed nursing staff. During an interview on 7/25/18 at 4:17 PM certified staff C reported if a resident asked for something for pain he/she asked the resident where he/she hurt and to rate how bad it hurt.	S3200		

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S3200	Continued From page 6 Staff would then call the nurse and then the nurse would tell the certified staff to go ahead and administer the medication. Staff C stated the certified medication was then supposed to go back later and ask the resident if the pain was any better or not. During an interview on 7/25/18 at 3:41 PM administrative nursing staff A reported certified staff needed to contact the licensed nurse for approval to administer any "as needed" medication and then document on the back of the MAR why they gave it and if it was effective or not. Review of the medication administration guidelines policy dated 5/2016 revealed staff needed to document results after giving the "as needed" medication but did not identify the need for a nurse to assess for effectiveness of the medication. The administrator failed to ensure staff followed standards of practice for the administration of "as needed" medications.	S3200		