Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	R 09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD WICHITA, KS 67206

(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	{S 000}		
{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 41 residents. The sample included 3 residents. Based on record review and interview for 3 (#2100, #2300, and #2200) of 3 residents sampled, administrator B failed to ensure medications were administered to each resident in accordance with a medical care provider's written order and standards of practice.	{S3200}		

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

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{S3200}	Continued From page 1 Findings included: - Record review for resident #2100 revealed an admission date of 8/14/18 with diagnoses of dementia, coronary artery disease, congestive heart failure, anemia, and hypertension. Functional capacity screen dated 8/14/18 indicated resident was unable to perform medication management and experienced impaired short-term memory, memory recall, and decision making. Negotiated service agreement and health care service plan, each dated 8/21/18 did not specify who provided medication management for the resident. Review of the August 2018 medication administration record (MAR) and the September 2018 MAR each documented facility certified medication aides and licensed nurses administered medications to the resident. Resident's record contained a written medical care provider's written order for each medication listed on each MAR. The August 2018 MAR contained documentation that the resident did not receive Quetiapine (to treat schizophrenia, bipolar disorder, and major depressive disorder) 25 milligrams (mg) tablet at 8:00 a.m. on 8/15/18 and Tamulosin (to improve urinary flow) 0.4 mg capsule at 8:00 p.m. on 8/29/18 and 8/30/18 due to "pharmacy has not delivered it yet." The MAR indicated resident did not receive Quetiapine 25 mg tablet at 8:00 a.m. on 8/15/18 due to "outside of parameters." The MAR did not include parameters for the Quetiapine.	{S3200}		

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{S3200}	Continued From page 2 The September 2018 MAR contained documentation that resident did not receive Tamulosin 0.4 mg tablet at 8:00 p.m. on September 1, 2, 3, 4, 5, 6, 7, 8, and 9, 2018 with documentation for each missed dose of "pharmacy has not delivered it yet." The MAR documented resident did not receive aspirin (heart health) 81 mg tablet on September 3, 4, 5, 2018; Donepezil (to treat dementia) 10 mg tablet on September 2, 3, 4, 2018; Docusate Sodium (stool softener) 100 mg capsule at 5:00 p.m. on September 4, 2018; Iron sulfate 325 mg tablet (supplement to treat anemia) at 8:00 a.m. on September 2, 3, 4, 2018; Furosemide (diuretic to treat congestive heart failure) 20 mg tablet at 8:00 a.m. on September 2, 3, 4, 2018; and Omeprazole (stomach acid reducer) 20 mg capsule at 8:00 a.m. on September 2, 3, 4, 2018. Certified medication aides and licensed nurses documented on the MAR "pharmacy has not delivered yet" or "med not available, not refilled" as the reason medications were not administered. - Record review for resident #2300 revealed an admission date of 3/6/18 with diagnoses of vascular dementia, atrial fibrillation, and hypertension. Functional capacity screen dated 8/12/18 indicated resident was unable to perform medication management and experienced impaired short-term memory, long-term memory, memory recall, and decision making. Negotiated service agreement and health care service plan, each dated 9/15/18 did not specify who provided medication management for the resident.	{S3200}		

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{S3200}	Continued From page 3	{S3200}		

The September 2018 MAR contained documentation that resident did not receive the following medications at 8:00 a.m. on 9/4/18: Citalopram (to treat depression) 20 mg tablet, Hydrocodone/acetaminophen (pain control) 5 mg/325 mg tablet, Lisinopril (to treat hypertension) 20 mg tablet, Metoprolol (to treat hypertension) 25 mg tablet, Ranitidine (stomach acid reducer) 150 mg tablet, Risperidone (to treat schizophrenia, bipolar disorder), and Thera-M (supplement)1 tablet. A certified medication aide documented on the MAR "pharmacy has not delivered it yet" for each medication not administered at 8:00 a.m. on 9/4/18. The September 2018 MAR contained documentation that resident did not receive Warfarin (to prevent blood clot formation) 3 mg tablet at 5:00 p.m. on 9/7/18 because "pharmacy has not delivered it yet." Resident's record contained a written medical care provider's written order for each medication listed on the MAR.

- Record review for resident #2200 revealed an admission date of 7/6/18 with diagnoses of dementia and type 2 diabetes mellitus.

Functional capacity screen dated 8/12/18 indicated resident was unable to perform medication management and experienced impaired short-term memory, long-term memory, memory recall, and decision making.

Negotiated service agreement and health care service plan, each dated 9/15/18 did not specify who provided medication management for the resident.

The September 2018 MAR contained documentation that resident did not receive Tamulosin (to improve urine flow) 0.4 mg 1

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{S3200}	Continued From page 4 capsule at 8:00 p.m. on 9/3/18 with documentation of "Pharmacy has not delivered it yet." Resident's record contained a written medical care provider's written order for the medication. During an interview at 3:19 p.m. on 9/26/18, licensed nurse C stated if medications were documented by a certified medication aide (CMA) or licensed nurse as unavailable from pharmacy and pharmacy was notified to deliver the medications, and resident did then receive the medication, CMAs and licensed nurse were unable to document on the electronic MAR that the medications were administered. Licensed nurse C confirmed could not verify if resident did or did not receive ordered medications. At 3:25 p.m. on 9/26/18, licensed nurse C reported he/she talked with CMA D who confirmed he/she did not give resident #2300 the Warfarin 3 mg tablet on 9/7/18. Licensed nurse C also stated CMA D did not call the pharmacy to deliver the medication and did not report to the licensed nurse on duty that resident did not receive Warfarin as ordered. Administrator B failed to ensure medications were administered to residents #2100, #2300, and #2200 in accordance with a medical care provider's written order and standards of practice.	{S3200}		