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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with investigation of complaint #134115 of the above residential health care facility on 2/12/19, 2/13/19, 2/14/19, 2/18/19, and 2/19/19.	S 000		
S3026 SS=K	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 51 residents. The sample included 3 residents, 37 residents (identified by licensed nurse C to be at risk for elopement) focus reviewed, 1 resident focus reviewed related to medication management, and 1 closed record reviewed. Based on record review, interview, and observation for 1 (#717) of 3 residents sampled and 10 (#720, #721, #722, #723, #724, #725, #726, #727, #728, and #729) of 37 residents focus reviewed, operator B failed to ensure no resident was subjected to neglect when potential exits from each of the 4 houses were not adequately monitored and a licensed nurse did not plan and implement health care interventions for each cognitively impaired resident assessed to be at risk for elopement.	S3026		

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

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Resident #717 eloped from the facility on 6/17/18 when staff members did not hear the exit door alarm, staff returned resident to facility, and no interventions were put into place to address resident's risk for elopement. The facility's investigation did not determine how resident was able to leave facility without staff knowledge and no corrective action taken to ensure staff members could hear alarm on exit doors. These failures placed each of the 11 residents at risk for elopement in immediate jeopardy for harm, injury, or death.

Findings included:

- Record review for resident #717 revealed an admission date of 4/10/17 with diagnoses of dementia, depression, dysphagia, and hypothyroidism.

Functional capacity screens dated 4/10/17 and 12/6/18 each indicated resident was independent with transferring and ambulation with walker; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and was at risk for falls.

Record contained elopement risk assessments dated 4/10/17 and 11/28/18, each completed by a licensed nurse. The assessment instructed the nurse completing the assessment that if any of the statements numbered 2 through 5 were checked as pertaining to the resident in conjunction with statement #1 resident was automatically placed at risk for elopement and the risk to be addressed in the health care service plan. The form also instructed the nurse to complete the elopement risk assessment upon resident's admission, annually, and in the event of elopement. On the elopement risk assessment

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dated 4/10/17 a licensed nurse checked statement #1 that "Resident has a medical diagnosis that indicates Alzheimer's, dementia, psychiatric diagnosis, or delirium." Licensed nurse also checked statement #2 that "Resident has a history of wandering or pacing while trying to open doors, windows, and/or gates." The licensed nurse completing the 11/28/18 elopement risk assessment also checked statements #1 and #2.

Health care service plans dated 4/7/17 and 12/6/18 each lacked interventions to address resident's risk for elopement.

During an interview at 1:25 p.m. on 2/13/19, certified staff N stated he/she kept a close eye on resident, asked resident where he/she was going and redirect, and on nice days would go outside with resident.

Wellness notes contained an entry by licensed nurse E dated 6/17/18 (nurse did not write the time entry was made) that at 6:40 p.m. a certified staff person called this nurse to report a call was received from another resident's family member reporting an elderly person with a walker was walking west on Meadowlark. Another nurse went to investigate and returned resident back to facility at 6:48 p.m. Assessment documented of vital signs blood pressure 118/61, pulse 87, respirations 18, temperature 98.6 degrees Fahrenheit, SpO2 (peripheral capillary oxygen saturation) 91% on room air, redness to top of head which went away, perspiration noted to hair and face, and no injury noted. Water provided, and resident encouraged to drink. Durable power of attorney and medical care provider made aware of incident. Doors were locked, and staff reported that the alarm to the side door by

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laundry room was sounding at the time of the incident.

Record lacked an elopement risk assessment after the resident eloped and health care service plan continued to lack interventions to address risk for elopement.

Facility investigation of the incident included the following statements:

Licensed nurse F 6/17/18 at 6:40 p.m. documented that he/she found resident walking on sidewalk "half-way down Meadowlark" and escorted resident safely back to facility.

Certified staff G 6/17/18 documented that he/she received a phone call from another resident's family member that an elderly person was walking west on Meadowlark toward Dillon's (grocery store 0.6 mile from facility) with a walker. Certified staff G immediately called and reported this to nurse.

Certified staff H 6/17/18 that at 6:45 p.m. he/she left house 2, heard alarm sounding from staff entrance door in house 3, and observed (certified staff J) come outside to look for any residents.

Certified staff J 6/17/18 at 6:40 p.m. wrote statement that he/she had last seen resident #717 wandering halls at 6:25 p.m. Certified staff J took another resident to his/her room to provide incontinence care and heard another resident's bed alarm sound with certified staff K responding to the bed alarm. When certified staff J finished providing care he/she went to do computer charting and certified staff K was working in the kitchen. After finishing computer charting, certified staff J noticed resident #717 was not in

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his/her room and both employees started looking for resident in the house. Certified staff J documented that as soon as he/she opened double doors he/she could hear alarm and went outside to look for resident with the assistance of certified staff H. Certified staff J documented after a few minutes of searching he/she saw a nurse pushing resident who was seated on his/her walker back to the house.

Certified staff K 6/17/18 at 6:40 p.m. wrote statement that included resident was last toileted at 6:00 p.m. and then was wandering up the hall with walker. Certified staff K heard a resident's bed alarm sound while certified staff J was in another resident's room. Certified staff K went to provide care to the resident. When both staff members were finished with care to other residents, certified staff J noticed resident #717 was not in his/her room and heard door alarm. Certified staff K documented "The door alarm was barely heard because both doors in the hall way were shut like they are supposed to be."

Licensed nurse C on 6/19/18 documented in his/her investigation of the elopement a corrective action given for certified staff K leaving floor unattended and an all staff meeting to be held on 7/6/18 on proper procedures of missing residents and door alarms. Licensed nurse C included in his/her investigation documentation of staff meeting held 7/6/18 and the missing resident procedure.

During an interview at 11:25 a.m. on 2/12/19, surveyor asked operator B if investigation included why staff members could not hear back door alarm when in a resident's room providing care and corrective action taken to ensure alarms were audible to staff members. Operator B

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stated staff members were instructed to leave one of the double doors open to hear the back-door alarm. Operator B stated he/she could faintly hear the alarm if he/she was in a resident room with one of the double doors open. Surveyor informed operator B that surveyor observed the double doors closed in each of the 4 houses during tour on 2/12/19. Operator B was unable to state any corrective action to ensure staff members were alerted when an exit door was opened.

During this same interview at 11:25 a.m. on 2/12/19, licensed nurse C stated there were 2 certified staff members on duty on each shift in each of the 4 houses and were instructed to always have one staff member on the floor when the other staff member was providing care to a resident. Licensed nurse C stated if another resident required care then the certified staff member on the floor was to call the nurse assigned to all 4 houses or the certified medication aide assigned to 2 houses to come to that house to be available while both certified staff members were providing care to residents.

During an interview at 11:12 a.m. on 2/14/19, licensed nurse C stated exit door alarms will sound until a staff member turns the alarm off with a key. Licensed nurse C stated he/she was told that resident was located on the sidewalk on the south side of Meadowlark (facility sits off on a street south of Meadowlark) by a crosswalk that goes north across Meadowlark. Surveyor observed a speed limit of 45 miles per hour in this area on the four-lane street and crosswalk 0.2 mile from the house where resident lived. Wunderground.com documented a temperature of 92 to 94 degrees Fahrenheit during the time the resident was out of the facility on 6/17/18.

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S3026	Continued From page 6 Tour of the facility kitchen in each of the 4 houses on 2/12/19 and 2/13/19 revealed an unlocked gate across each of the 2 entrances to the open kitchen. There was an exit door in each kitchen to a locked courtyard. Surveyor opened the kitchen door in house #1 and observed no alarm sounded to alert staff that the door was opened. At 10:19 a.m. on 2/13/19 in house #3, surveyor opened door in kitchen, went into enclosed courtyard, and observed that the door did open from the outside and was not locked. Certified staff L stated there was not an alarm on the kitchen door. At 11:44 a.m. on 2/13/19 in house #4, operator B stated the exit door to the courtyard in each house was not alarmed but added that that each courtyard gate was locked. Operator B stated and confirmed a resident would not be safe if in the courtyard without staff knowledge. Operator B stated he/she would try to get alarms for the doors to alert staff if a resident went into the courtyard unattended. At this same time, surveyor asked licensed nurse C to set off the back-door alarm. Surveyor went to the resident room and left the door open farthest from the back door and was unable to hear the alarm. Operator B also present in this area and stated he/she could hear the alarm. Then surveyor went with operator B and licensed nurse C to house #3 and able to faintly hear back door alarm from hallway farthest from the back door. On 2/14/19 at 3:15 p.m. in house #1, management staff M set off the back-door alarm and surveyor unable to hear in kitchen area or in den area with no background noise present. Certified staff N stated he/she could faintly hear the alarm from the kitchen and had to keep	S3026		

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double doors open to hear the alarm.

At 3:49 p.m. on 2/14/19, operator B set off the back-door alarm in house #2. Surveyor and licensed nurse C unable to hear the alarm in the kitchen/dining area due to resident activity in progress. Surveyor and licensed nurse C able to hear the alarm once away from background noise.

During an interview at 1:51 p.m. on 2/13/19, when surveyor asked for interventions in health care service plan to address resident's risk for elopement, licensed nurse C stated locked unit (facility) was the intervention. Licensed nurse C stated an elopement risk assessment was not completed after the resident eloped from the facility and health care service plan was not updated.

- At 11:00 a.m. on 2/14/19, surveyor asked operator B for licensed nurse C to list residents assessed to be at risk for elopement. Licensed nurse C provided a list of 38 residents. Focus record review of 36 of the 38 residents (resident #717 was sampled and one resident record was unavailable) listed revealed each resident had an elopement risk assessment with 10 (#720, #721, #722, #723, #724, #725, #726, #727, #728, and #729) of these residents documented to be at risk for elopement.

Record review for resident #720 revealed an admission date of 9/4/18 with diagnosis of dementia. Elopement risk assessment dated 4/16/18 documented resident with diagnosis of dementia and "Resident has a history of wandering or pacing while trying to open doors, windows, and/or gates." Health care service plan dated 9/4/18 lacked interventions to address

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resident's risk for elopement.

Record review for resident #721 revealed an admission date of 2/6/18 with diagnosis of vascular dementia. Elopement risk assessment dated 11/16/18 documented resident with diagnosis of dementia and "Resident expresses anger at nursing home or assisted living placement or verbalizes desire to leave community without just cause." Health care service plan dated 2/5/19 lacked interventions to address resident's risk for elopement.

Record review for resident #722 revealed an admission date of 7/19/18 with diagnosis of dementia with behaviors. Elopement risk assessment dated 11/28/18 documented resident with diagnosis of dementia and "Resident has a history of wandering or pacing while trying to open doors, windows, and/or gates." Health care service plan dated 7/18/18 lacked interventions to address resident's risk for elopement. Wellness notes contained an entry by a licensed nurse dated 8/14/18 that resident got spouse in wheelchair and was adamant they were leaving. Staff member took resident to courtyard where resident put a chair next to gate and attempted to climb over fence.

Record review for resident #723 revealed an admission date of 7/6/18 with diagnosis of dementia. Elopement risk assessment dated 11/22/18 documented diagnosis of dementia and "Resident has a history of wandering or pacing while trying to open doors, windows, and/or gates." Health care service plan dated 7/5/18 lacked interventions to address resident's risk for elopement.

Record review for resident #724 revealed an

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admission date of 4/4/18 with diagnosis of dementia. Elopement risk assessment dated 4/6/18 documented diagnosis of dementia and "Resident has a history of wandering or pacing while trying to open doors, windows, and/or gates. Resident expresses anger at nursing home or assisted living placement or verbalizes desire to leave community without just cause. Resident has a past history of elopement from the home or facility environment" Health care service plan dated 12/12/18 lacked interventions to address resident's risk for elopement.

Record review for resident #725 revealed an admission date of 4/1/17 with diagnosis of dementia. Elopement risk assessment dated 11/21/18 documented diagnosis of dementia and "Resident has a history of wandering or pacing while trying to open doors, windows, and/or gates." Health care service plan dated 4/4/18 lacked interventions to address resident's risk for elopement.

Record review for resident #726 revealed an admission date of 3/18/16 with diagnosis of Alzheimer's disease. Elopement risk assessment dated 11/21/18 documented diagnosis of Alzheimer's disease and "Resident has a history of wandering or pacing while trying to open doors, windows, and/or gates." Health care service plan dated 12/13/18 lacked interventions to address resident's risk for elopement.

Record review for resident #727 revealed an admission date of 1/24/18 with diagnosis of dementia. Elopement risk assessment dated 11/22/18 documented diagnosis of dementia and "Resident has a history of wandering or pacing while trying to open doors, windows, and/or gates." Health care service plan dated 11/13/18

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S3026	Continued From page 10 lacked interventions to address resident's risk for elopement. Record review for resident #728 revealed an admission date of 11/4/16 with diagnosis of dementia. Elopement risk assessment dated 11/21/18 documented diagnosis of dementia and "Resident has a history of wandering or pacing while trying to open doors, windows, and/or gates." Health care service plan dated 1/29/19 lacked interventions to address resident's risk for elopement. Record review for resident #729 revealed an admission date of 11/11/16 with diagnosis of dementia. Elopement risk assessment dated 11/22/18 documented diagnosis of dementia and "Resident has a history of wandering or pacing while trying to open doors, windows, and/or gates." Health care service plan dated 4/4/18 lacked interventions to address resident's risk for elopement. At 3:45 p.m. on 2/14/19, licensed nurse C provided "Negotiated Service Agreement Amendment" that listed interventions to address elopement risk for each resident he/she had listed at risk for elopement. Licensed nurse C stated each resident's durable power of attorney would be contacted to discuss the interventions and sign the form. Operator B failed to ensure no resident was subjected to neglect when potential exits from each of the 4 houses were not adequately monitored and a licensed nurse did not plan and implement health care interventions for each cognitively impaired resident assessed to be at risk for elopement.	S3026		

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S3026	Continued From page 11 The immediate jeopardy was corrected at 2:21 p.m. on 2/14/19 when operator B provided a written plan for each of the 4 houses and all residents: We are installing a door sensor on the kitchen exit door, that will send a signal to the alarm speaker each time the door is opened. This alarm will be located on the kitchen countertops and will not stop alarming until reset by staff, which will ensure they are alerted that the door has been opened. Staff will respond to the door alarm, walk out the door to search who went through the door. We are also installing another sensor on the back door, located next to the laundry room. This will also send a signal to the alarm speaker, located on the kitchen countertops, each time the door is opened. This will also continue to alarm until reset by staff, so they are alerted to the door being opened. Staff will respond to the door alarm, go out the door to search each time to verify who went through the door. All staff will be trained on how to operate and properly reset the door alarm system. We will go through the charts of every resident and update their chart for their elopement risk and interventions updated. Staff will be instructed of these changes. Staff will be informed on 2/14/19, and at the beginning of their next scheduled shift. Charts will be completed by 2/22/19. The system will be installed 2/14/19.	S3026		

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S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c)(1)(2) The facility reported a census of 51 residents. The sample included 3 residents, 37 residents (identified by licensed nurse C to be at risk for elopement) focus reviewed, 1 resident focus reviewed related to medication management, and 1 closed record reviewed. Based on record review and interview for 1 (#717) of 3 residents sampled, licensed nurse C failed to conduct a screening to determine the resident's functional capacity following a significant change in condition and at least every 365 days. Findings included: - Record review for resident #717 revealed an admission date of 4/10/17 with diagnoses of dementia, depression, dysphagia, and hypothyroidism. The record contained a functional capacity screen dated 12/6/18, marked as an annual screening,	S3081		

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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
S3081	Continued From page 13	S3081		

that indicated resident was independent with transferring self and walking with a walker; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and was at risk for falls.

Wellness notes contained an entry by licensed nurse E on 6/17/18 that at 6:40 p.m. a certified employee notified this nurse that a person called facility to report an elderly person was walking west from facility on a sidewalk with a walker. Licensed nurse (F) left facility to investigate and found and returned (resident #717) to the facility at 6:48 p.m. The negotiated service agreement and health care service plan dated 12/6/18 lacked interventions related to the resident's risk for elopement.

At 10:30 a.m. on 2/13/19, licensed nurse C provided the resident's previous functional capacity screen that was dated 4/10/17 which also indicated resident was independent with transferring self and walking with a walker; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and was at risk for falls.

At 11:01 a.m. on 2/13/19, licensed nurse C stated he/she did not conduct a screening after the resident eloped from the facility and did not conduct an annual screening after the 4/10/17 functional capacity screen.

Licensed nurse C failed to conduct a screening to determine resident #717's functional capacity following a significant change in condition and at least every 365 days.

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	N087073	A. BUILDING: _____ B. WING _____	02/19/2019

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S3155	Continued From page 14	S3155		
S3155 SS=E	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 reported a census of 51 residents. The sample included 3 residents, 37 residents (identified by licensed nurse C to be at risk for elopement) focus reviewed, 1 resident focus reviewed related to medication management, and 1 closed record reviewed. Based on record review, interview, and observation for 2 (#717 and #716) of 3 residents sampled, operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #717 revealed an admission date of 4/10/17 with diagnoses of dementia, depression, dysphagia, and hypothyroidism.	S3155		

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S3155	Continued From page 15 Functional capacity screen dated 12/6/18 indicated resident was independent with transferring and ambulation with walker; required physical assistance with eating; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and was at risk for falls. Negotiated service agreement dated 12/6/18 documented resident was independent with transferring and ambulation; resident requests assistance in having food cut up, prompting, etc.; mechanical soft diet with nectar thick liquids; and judgement is frequently poor, needs supervision. Health care service plan dated 12/6/18 documented health care services of mechanical soft diet with nectar thick liquids, potential risks related to falls and impaired decision making. Record contained "Dysphagia Precautions " written by a speech pathologist on 3/8/18 with instructions to staff members to crush medications with applesauce/pudding; mechanical soft diet with ground meats and honey thick liquids; close monitoring and resident sit upright at 90 degrees in chair at mealtimes; resident to take small bites/sips and alternate liquids with solids every 2 to 3 bites; and after meals staff member to check mouth for pocketing of food, have resident clear mouth, and resident to remain upright for 30 minutes. Health care service plan dated 12/6/18 did not describe the dysphagia precautions for staff members to follow at mealtime for resident. At 11:53 a.m. on 2/14/19, surveyor observed resident feeding self mashed potatoes and	S3155		

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ground meat with 2 glasses of thickened liquids while seated at dining room table with other residents. Resident took sips of liquid every few bites. Staff members were in the area during this time. Surveyor observed resident finish meal and continue to sit at table at least 30 minutes drinking the remainder of liquids. Surveyor did not observe a staff member check to see if resident had pocketed food in mouth.

During an interview at 1:25 p.m. on 2/13/19, when asked about precautions at mealtimes certified staff N stated "Just make sure has mechanical" soft diet. Certified staff N confirmed resident required thickened liquids to drink.

During an interview at 1:51 p.m. on 2/13/19, licensed nurse C stated and confirmed resident's health care service plan lacked a description of services related to resident's diagnosis of dysphagia.

Resident's record contained elopement risk assessments dated 4/10/17 and 11/28/18, each completed by a licensed nurse. The assessment instructed the nurse completing the assessment that if any of the statements numbered 2 through 5 were checked as pertaining to the resident in conjunction with statement #1 resident was automatically placed at risk for elopement and the risk to be addressed in the health care service plan. The form also instructed the nurse to complete the elopement risk assessment upon resident's admission, annually, and in the event of elopement. On the elopement risk assessment dated 4/10/17 a licensed nurse checked statement #1 that "Resident has a medical diagnosis that indicates Alzheimer's, dementia, psychiatric diagnosis, or delirium." Licensed nurse also checked statement #2 that "Resident

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has a history of wandering or pacing while trying to open doors, windows, and/or gates." The licensed nurse completing the 11/28/18 elopement risk assessment also checked statements #1 and #2.

Health care service plan dated 12/6/18 lacked interventions to address resident's risk for elopement.

During an interview at 1:25 p.m. on 2/13/19, certified staff N stated he/she kept a close eye on resident, asked resident where he/she was going and redirect, and on nice days would go outside with resident.

Wellness notes contained an entry by licensed nurse E dated 6/17/18 (nurse did not write the time entry was made) that at 6:40 p.m. a certified staff person called this nurse to report a call was received from another resident's family member reporting an elderly person with a walker was walking west on Meadowlark. Another nurse went to investigate and returned resident back to facility at 6:48 p.m. Assessment documented of vital signs blood pressure 118/61, pulse 87, respirations 18, temperature 98.6 degrees Fahrenheit, SpO2 (peripheral capillary oxygen saturation) 91% on room air, redness to top of head which went away, perspiration noted to hair and face, and no injury noted. Water provided, and resident encouraged to drink. Durable power of attorney and medical care provider made aware of incident. Doors were locked, and staff reported that the alarm to the side door by laundry room was sounding at the time of the incident.

During an interview at 11:25 a.m. on 2/12/19, licensed nurse C stated there were 2 certified

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staff members on duty on each shift in each of the 4 houses and were instructed to always have one staff member on the floor when the other staff member was providing care to a resident. Licensed nurse C stated if another resident required care then the certified staff member on the floor was to call the nurse assigned to all 4 houses or the certified medication aide assigned to 2 houses to come to that house to be available while both certified staff members were providing care to residents. Licensed nurse C stated when resident's elopement occurred, each staff member was in a resident's room providing care and did not call the nurse or certified medication aide to be present in the house at this time.

During an interview at 1:51 p.m. on 2/13/19, when surveyor asked for interventions in health care service plan to address resident's risk for elopement, licensed nurse C stated locked unit (facility) was the intervention. Licensed nurse C stated he/she did not add interventions to the health care service plan to address resident's risk for elopement

Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #717 and were in accordance with the functional capacity screening and the negotiated service agreement.

- Record review for resident #716 revealed an admission date of 8/16/18 with diagnoses of dementia and atrial fibrillation.

Functional capacity screen dated 8/9/18 indicated resident was independent with transferring and walking with a walker and experienced impaired short-term memory, long-term memory, memory

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recall, and decision making.

Negotiated service agreement dated 8/9/18 documented "Attitudes, habits, and emotional states do not create unusual demands on others. Resident is not oriented to time or place and cannot remember or use information. Judgement is frequently poor; needs supervision."

Health care service plan dated 8/9/18 did not include a description of health care services to address resident's impaired cognition.

Wellness notes contained the following entries:

9/24/18 at 1:00 p.m. a licensed nurse documented resident with increased aggression and anxiety, redirected with activity. Medical care provider contacted and received order for Ativan o.5 milligram topical every 4 hours as needed for anxiety.

12/2/18 licensed nurse documented resident hit another resident in the head. The nurse documented an intervention of will have medical care provider review medications.

12/5/18 licensed nurse documented staff reported at around 6:30 p.m. resident had increased behaviors of yelling, calling names, grabbing/pushing staff. Another resident tried stepping in to help and resident (#716) tried to "go after" that resident. Staff redirected resident but still easily angered and Ativan given.

12/8/18 licensed nurse documented that at 12:00 p.m. staff reported resident hit another resident in the arm, hit a staff member in the face, and twisted the arm of another staff member. Ativan given and received order from medical care

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S3155	Continued From page 20 provider to send resident to behavior unit. 12/19/18 resident returned to facility from behavior unit. The health care service plan was not updated with interventions for management of behaviors. During an interview at 12:52 p.m. on 2/13/19, certified staff O stated he/she had been instructed to redirect resident when exhibiting behaviors. During an interview at 2:13 p.m. on 2/13/19, licensed nurse C stated behavior management interventions were not in the health care service plan. Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #716 and were in accordance with the functional capacity screening and the negotiated service agreement.	S3155		
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	S3214		

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S3214	Continued From page 21 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 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.	S3214		

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S3214	Continued From page 22 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(4)(E)(F) The facility reported a census of 51 residents. The sample included 3 residents, 37 residents (identified by licensed nurse C to be at risk for elopement) focus reviewed, 1 resident focus reviewed related to medication management, and 1 closed record reviewed. Based on observation, record review, and interview for 1 (#718) of 1 resident focus reviewed, operator B failed to ensure the development and implementation of a policy and procedure for receiving and identifying a sample medication that included the following conditions: 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 including the strength, dosage, route, frequency of administration, and any cautionary instructions as documented on the medical care provider's order. 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. Findings included:	S3214		

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S3214	Continued From page 23 - During tour of the medication room at 10:53 a.m. on 2/13/19, certified staff D removed a box containing 3 Myrbetriq (for treatment of overactive bladder) 50 milligram (mg) tablets. The box was labeled with resident's full name but lacked the medication name including the strength, dosage, route, frequency of administration, and any cautionary instructions as documented on the medical care provider's order. Certified staff D provided 3 more boxes of the same medication each labeled with the resident's name only. Certified Staff D stated resident received 1 tablet by mouth daily. Record review or resident #718 revealed an admission date of 11/29/18 with diagnosis of dementia. Functional capacity screen dated 11/28/18 indicated resident was unable to perform medication management. Negotiated service agreement dated 11/28/18 documented staff administered all medications to resident. Medical care provider notes 12/6/18 documented diagnosis of overactive bladder, resident to continue taking Myrbetriq with samples provided. The record lacked documentation that a licensed nurse informed the resident's family member that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist that required identification of both adverse drug interactions or reactions and potential allergies. At 11:32 a.m. on 2/13/19, licensed nurse C, while looking for the facility's sample medication policy and procedure, stated he/she was aware (resident #718) had a sample medication because the medication was costly for the family. Operator B arrived with the policy and procedure for sample medications and stated he/she was	S3214		

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S3214	Continued From page 24 unaware any resident had a sample medication. At 11:39 a.m. on 2/13/19, licensed nurse C stated and confirmed a licensed nurse did not inform the resident's family member that the medication did not go through the usual process of labeling an initial review by a licensed pharmacist and sample medication label did not include all required information. For resident #718, operator B failed to ensure the development and implementation of a policy and procedure for receiving and identifying a sample medication.	S3214		