Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089033	A. BUILDING: _____ B. WING _____	04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEGGY KELLY HOUSE I	2111 SW RANDOLPH AVE TOPEKA, KS 66614

(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 are the result of a Licensure Resurvey at the above named Home Plus Facility in Topeka, Kansas on 4/15/14, 4/16/14, and 4/17/14.	S 000		
S5251 SS=D	26-42-105 (f) (11) Resident Records 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 26-42-105(f)(11) The census equalled 10 the sample include three Residents. Based on reviews of records and interviews, for one of two sampled Residents with incidents/accidents that resulted in injury (#187), the Operator failed to ensure the medical record included 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. Findings included: - Review of record revealed #187 admitted to facility 5/01/13 with diagnoses of Hypertension, Panic attacks, Parkinson's, Hyperlipidemia, Psychosis, Gastroesophageal reflux, Dementia, Hypothyroid, Diabetes, and Diverticulosis. The current functional capacity screen (FCS) of 01/13/14 assessed #187 in need of physical assistance with bathing, dressing, toileting,	S5251		

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

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S5251	Continued From page 1	S5251		

transfers, and mobility; unable to perform medication and treatment management; and with memory, recall, and decision making impairments. The medical record contained a Nurse's Note dated 01/13/14 at 0930: RN (registered nurse) called and updated this nurse regarding #187 over the weekend. Resident with falls, not sitting up will leaning to right side... family here... Hospice notified this weekend... This morning Resident with pinkness over right eye, no open areas. Right elbow with Tegaderm in place, skin tear present... pharmacy to do medication review... call out to Dr. to notify of above."
The Nurse's note lacked documentation of the "falls" that occurred, the time, the date, actions taken, results of the action, and an assessment of the Resident's symptoms and any injuries that occurred.

By interview on 4/16/14 at 5:07pm, Operator/Licensed nurse #B stated no other documentation available in medical record, but additional information in our risk management file on computer as follow-up.

By observation Operator/Licensed nurse #B accessed the file that documented events referred to in the above 01/13/14 Nurse's Note. Accessed information documented:
"Occurred on 01/11/14 at 1200; quarter size abrasion to right knee; purple bruising and some swelling to Left hip area; large purple bruises to right wrist and back of right hand; Resident with approximately 3 centimeter in length, quarter size area with skin missing, unable to approximate edges. Cleanse with soap and water and covered with Tegaderm; daughter arrived and found Resident on the floor in between the closet and the end of the bed... on duty staff called RN... RN

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S5251	Continued From page 2 to facility completed evaluation of Resident #187... #187 unable to say what happened... staff instructed to use wheelchair and administer pain medication if needed..." The Operator failed to ensure the medical record for #187 included 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.	S5251		
S5316 SS=D	26-42-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist.	S5316		

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S5316	Continued From page 3 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(i) The census equalled 10 the sample included three Residents. The facility identified all Residents with facility managed medications. Based on observations, interviews, and reviews of records, for one of one controlled medication reconciliation review, the Licensed nurses and Medication aides failed to follow facility policy and procedure to ensure an accurate accounting of controlled medications. Findings included: - Observation on 4/15/14 at 4:20pm, with Certified Medication aide (CMA) #A revealed the inaccurate count of Hydrocodone 5-325 (a narcotic) for non-sampled Resident #183. The noon punch card of medication contained six tablets, and the documented count sheet recorded five tablets. By review of the shift to shift controlled medication log, an entry for 4/15/14 "7am" contained two signatures, an on-coming CMA, and an off-going CMA, per facility Narcotic control policy. The entry on this same log for 4/15/14 at "3pm" contained one signature, that of the off-going CMA #C. This entry lacked a signature for the on-coming, CMA #A. On 4/15/14 at 4:40pm CMA #A and Operator/Licensed Nurse #B confirmed the controlled medication log not signed at 3:00pm per facility policy... not sure why the count	S5316		

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S5316	Continued From page 4 inaccurate with an extra tablet present for #183's noon Hydrocodone at this time, when counted approximately one hour earlier. Review of facility policy and procedure titled "Storage of Drugs and Biologicals/Narcotic control" documented: #7 All narcotics will be counted at each shift change; #8 The on-coming CMA/nurse will count the narcotics and the off-going CMA/nurse will verify the count from the individual narcotic count sheets; #9 Both CMA's/nurses will sign the narcotics control record in the appropriate spaces. The Licensed nurses and Medication aides failed to follow facility policy and procedure to ensure an accurate accounting of controlled medications for #183.	S5316		