STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	03/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCRITE RETIREMENT ASSISTED LIVING	1608 SW 37TH ST TOPEKA, KS 66611

(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 Assisted Living Facility in Topeka, Kansas on 3/18/14, 3/19/14, and 3/20/14. Complaint #72102 also investigated.	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) The census equalled 52 the sample included three Residents. The facility identified nine Residents with outside providers. Based on observations, interviews, and reviews of records, for two of two sampled with outside service providers (#189 and #185), the Operator failed to	S3085		

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

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S3085	Continued From page 1 ensure the development of a written negotiated service agreement (NSA) that included identification of the provider of each service, and the payment source when services by an outside provider. Findings included: - Review of record revealed #189 admitted to facility 01/17/14 with diagnoses of Chronic obstructive pulmonary disease, Congestive heart failure, Atrial fibrillation, Anemia, Pleural effusion, Decreased hearing, Influenza, Atelectasis, and Pneumonia. The current functional capacity screen (FCS) of 01/17/14 assessed #189 in need of physical assistance with bathing, supervision with dressing, mobility, and incontinence; with short term memory and memory recall impairment; in need of physical assistance with medication management; unable to perform treatment management; with impaired vision and hearing, and with falls and unsteadiness. The current negotiated service agreement (NSA) of 01/17/14 documented assistance of staff with bathing, and supervision of dressing, mobility, incontinence, and fall prevention. The NSA contained an addendum of 01/31/14 that documented PT/OT (physical therapy/occupational therapy) services to begin. The NSA (addendum) lacked the name of the service provider and the payment source for this service by an outside provider. The medical record contained an 01/24/14 physician's order for oxygen 3L (liters) at rest to keep > 90% and 4L with exertion to keep > 90%. The NSA lacked the service for oxygen, lacked the name of the outside provider, and lacked the payment source.	S3085		

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S3085	Continued From page 2 On 3/19/14 at 2:12pm, Facility Nurse #A stated the name of the oxygen company that provided service to #189... #A reviewed the NSA and confirmed the oxygen service and payment source not specified on the NSA... By further review, the NSA contained a generic statement all services paid for by private pay, insurance, or by Medicare. By observation and interview in Resident's room on 3/19/14 at 2:55pm, #189 used oxygen provided from a concentrator, and extra tanks observed stored in corner of room. #189 stated I was switched from the little tanks to the big tanks... stated name of oxygen company visits about once a week... The Operator failed to ensure a written NSA developed for #189 that included a description of the services the Resident to receive (oxygen), identification of the provider of each service (Oxygen, PT, OT), and the payment source when services by an outside provider. - Review of record revealed #185 admitted to facility 9/26/13 with diagnoses of Carotid artery disease, Hypercholesterolemia, Seizures, Congestive heart failure, Hypertension, Allergies, and Hypothyroidism. The 9/26/13 functional capacity screen (FCS) assessed #185 unable to perform medication and treatment management; independent with bathing, dressing, toileting, transfers, mobility, and continence. The medical record contained two hour checklists, and the record contained an order for oxygen (dated 8/19/13) O2 (oxygen) at 2L (liters) per minute via nasal cannula continuous to keep sats > 90%. In further review, the NSA lacked the needed and ordered service of Oxygen.	S3085		

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S3085	Continued From page 3 On 3/19/14 at 2:05pm, Facility Nurse #A confirmed the NSA lacked the service of Oxygen, the name of the provider, and the specific payment source. By further review, the NSA contained a generic statement all services paid for by private pay, insurance, or by Medicare. By observation on 3/19/14 at 5:20pm and 5:40pm in the dining room of facility, #185 utilized oxygen by nasal cannula and small portable tank. The Operator failed to ensure a written NSA developed for #185 that included a description of the services the Resident to receive (oxygen), identification of the provider of the service, and the payment source when services by an outside provider.	S3085		
S3175 SS=E	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually.	S3175		

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S3175	Continued From page 4 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The census equalled 52 the sample included three Residents. The facility identified 21 Residents with self administered medications, and two of these included in the sample. Based on observations, reviews of records and interviews, for two of two sampled with self administered medications (#189 and #187), the Operator failed to ensure an assessment performed to determine the Resident could safely and accurately self administer medications without staff assistance. Findings included: - Review of record revealed #187 admitted to facility 8/19/10 with diagnoses of Glaucoma, Hypertension, Ulcerative colitis, Osteoporosis, Neck pain, Dementia, Diabetes, and Toe ulcer. The current functional capacity screen (FCS) of 02/28/14 assessed #187 in need of physical assistance with medication and treatment management. The current negotiated service agreement (NSA) of 02/28/14 documented family member to set up medications weekly, staff remind three times daily, staff admininster eye drops twice daily. The medical record contained a self administration assessment form. This form contained the same statement: family member to set up medications weekly, staff remind three times daily, staff admininster eye drops twice daily. The self admininstration form contained a single line drawn across all 18 assessment considerations, to be coded as "unable", "able	S3175		

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S3175	Continued From page 5	S3175		

with assist", "fully capable", and "not applicable." The assessment form failed to document #187's functional, physical, and cognitive ability to safely self administer medications without staff assistance.

By interview on 3/19/14 at 11:15am, Facility Nurse #A stated #187 does not know what he/she takes or why... family sets up baggies weekly... nursing staff stores in a locked drawer... opens the drawer and tells #187 to take the appropriate baggie three times daily... family had concerns that #187 was not taking the appropriate baggie when getting medications from storage by self.

By observation and interview on 3/19/14 at 3:10pm, #187 stated family does my medications one time a week... spends quite a time. When asked what kind of medications or how many medications #187 takes daily, he/she stated "considerable." When asked to show where medications stored, #187 stood and started towards bedroom... paused... looked around living room briefly... then stated he/she did not know for sure where the medications were stored. Surveyor pointed at a seven day medication box on dining room table that contained four white oblong tablets in each day, and asked #187 if this is what he/she looking for. #187 stated those are not mine.

The Operator failed to ensure an assessment of #187's ability to safely and accurately self administer medications without staff assistance, completed and in the medical record.

- Review of record revealed #189 admitted to facility 01/17/14 with diagnoses of Chronic obstructive pulmonary disease, Congestive heart

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S3175	Continued From page 6	S3175		

failure, Atrial fibrillation, Anemia, Pleural effusion, Decreased hearing, Influenza, Atelectisis, and Pneumonia. The current functional capacity screen (FCS) of 01/17/14 assessed #189 in need of physical assistance with medication management and unable to perform treatment management. The current negotiated service agreement (NSA) of 01/17/14 documented Resident's pharmacy set up medications, staff provided reminders for Resident to take medications at appropriate time. The medical record contained a self administration assessment form. This form contained the same statement: Name of pharmacy doing med set up and staff to do med reminders. The self admininstration form contained a single line drawn across all 18 assessment considerations, to be coded as "unable", "able with assist", "fully capable", and "not applicable." The assessment form failed to document #187's functional, physical, and cognitive ability to safely self administer medications without staff assistance.

By interview on 3/19/14 at 2:00pm, Facility Nurse #A stated the self administration assessment form says does with reminders... in reality he/she doesn't know the medications and the times...

By observation and interview on 3/19/14 at 2:55pm, #189 initially stated I don't take any medications... after a short period, #189 stated I do have some... the Pharmacy fills box and staff is here to make sure I take when supposed to. When asked what medications he/she takes, or how often, #189 stated I don't know... but I think it is written on the box they set up... I think I have a blood pressure pill, but I don't know all of them...

The Operator failed to ensure an assessment of #189's ability to safely and accurately self

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S3175	Continued From page 7 administer medications without staff assistance, completed and in the medical record.	S3175		