Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

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S 000	INITIAL COMMENTS The following citations are the result of a Licensure Resurvey at the above named Residential Health Care Facility on 12/09/19, 12/10/19, and 12/11/19.	S 000		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced	S3028		

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

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S3028	Continued From page 1 by: KAR 26-41-101(f)(3) The census equalled 16 Residents the sample included three. Based on interview and review of records for two of three sampled (#131 and #130), the Operator failed to ensure each incident of potential abuse, neglect, or exploitation thoroughly investigated within five days of the event and a written record maintained of each incident investigation. Findings included: - Review of record revealed #130 admitted to facility 8/26/19 with diagnoses of traumatic brain injury, dysphagia, Schizophrenia, and alcohol abuse. Current Functional Capacity Screen (FCS) of 8/26/19 assessed #130 unable to perform (3) bathing, dressing, and management of medications and treatments; required physical assistance (2) with toileting, transfer, walk/mobility, and eating. Current Negotiated Service Agreement/ Health Care Service Plan dated 8/26/19 documented staff to provide physical assistance with bathing, dressing, toileting, transfer, walk/mobility, to manage medications and treatments, and staff to supervise eating. Resident Progress Note of medical record dated "10/21" (no year and no time) recorded: "on 10/19/19 noted Resident was given Lorazepam (anxiety and seizures) 0.5mg (milligrams) 1.5 tabs instead of Diazepam (anxiety and spasms) 7.5mg no reaction noted v/s (vital signs) WNL (within normal limits) fax sent to physician to	S3028		

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S3028	Continued From page 2	S3028		

notify." This entry indicated a medication error occurred.

The medical record lacked further investigation information such as time of medication error, how error occurred, how error discovered and by whom, who the error reported to and the directions given, physician's directions for monitoring, assessment of Resident results, and corrective action taken to prevent further errors. The medical record lacked documentation of the investigative process to rule out potential abuse, neglect, or exploitation.

On 12/10/19 at 3:08pm Operator/Registered nurse #A and facility Licensed nurse #B confirmed investigative steps taken to determine details... those details most likely on "Incident Reports" not considered part of the Resident's legal record... stated employee discussion and re-education also provided... confirmed the Resident's medical record lacked evidence of the investigative process.

The Operator failed to ensure for #130 a medication error incident reviewed was thoroughly investigated to rule out potential abuse, neglect, or exploitation and a written record maintained of each incident investigation.

- Review of record revealed #131 admitted to facility 9/02/19 with diagnoses of Alzheimer's.

Current Functional Capacity Screen (FCS) of 9/02/19 assessed #131 unable to perform (3) dressing, medication and treatment management; in need of physical assistance (2) with bathing, toileting, transfers; with incontinence, sometimes understood and sometimes understands

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S3028	Continued From page 3 communication, with impaired decision making, wandered, and used a walker. Current Negotiated Service Agreement of 9/02/19 documented #131 to receive staff assistance with these services. Resident Progress Notes of medical record included: 11/17/19 - sat up on side of bed and went over... abrasion to right side of head... assessment completed... 10/07/19 - Non injury fall on 10/04... states tried to get up from recliner, couldn't, slid down to floor... no injury noted. Educated to call for help getting up... The medical record lacked further investigation information such as time of the occurrence, where located, who discovered, what Resident was doing prior to these incidents, position found in, last time services provided to Resident, last time toileted, last eat or drink, who the incident reported to and the directions given. The medical record lacked documentation of the investigative process to rule out potential abuse, neglect, or exploitation. On 12/10/19 at 3:08pm Operator/Registered nurse #A and facility Licensed nurse #B confirmed investigative steps taken to determine details... those details most likely on "Incident Reports" not considered part of the Resident's legal record... stated new interventions documented on the nurse assessment form, and follow up to effectiveness of interventions also on the assessment form... confirmed the Resident's medical record lacked evidence of the investigative process.	S3028		

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S3028	Continued From page 4 The Operator failed to ensure for #131 falls experienced were thoroughly investigated to rule out potential abuse, neglect, or exploitation and a written record maintained of each incident investigation.	S3028		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The census equaled 16 Residents. The sample included three Residents. Based on interview and record review for two of three sampled (#129 and #130), the Operator failed to ensure that each individual involved in the development of the negotiated service agreement (NSA) signed the agreement. Findings included: - Record review for Resident #129 recorded admission date of 1/25/12 with diagnoses of Diabetes Mellitus type 2, chronic obstructive pulmonary disease, and congestive heart failure. Functional Capacity Screen dated 4/2/19 recorded Resident unable to perform (3) bathing, dressing, toileting, transfer, walk/mobility,	S3101		

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S3101	Continued From page 5 medication and treatment management, and needed physical assist (2) with eating. Negotiated service agreement/ health care service plan dated 4/2/19 recorded staff to provide physical assistance with bathing, dressing, toileting, transfer, walk/mobility, eating and to provide management of medications and treatments. NSA lacked signatures of the licensed nurse and the operator. - Record review for Resident #130 recorded admission date of 8/26/19 with diagnoses of traumatic brain injury, dysphagia, Schizophrenia, and alcohol abuse. Functional Capacity Screen dated 8/26/19 recorded Resident unable to perform (3) bathing, dressing, and management of medications and treatments; required physical assistance (2) with toileting, transfer, walk/mobility, and eating. Negotiated service agreement/ health care service dated 8/26/19 recorded staff to provide physical assistance with bathing, dressing, toileting, transfer, walk/mobility, to manage medications and treatments, and staff to supervise eating. NSA lacked signatures of the licensed nurse and operator. An addendum to the NSA dated 10/08/19 recorded a diet order change. The addendum lacked the signature of the Resident or the Resident's representative.	S3101		

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S3101	Continued From page 6 On 12/10/19 at 3:05pm Operator/Registered nurse #A and facility Licensed nurse #B confirmed the NSA's lacked signatures of all who participated. For Residents #129 and #130, the Operator failed to ensure that each individual involved in the development of the negotiated service agreement signed the agreement.	S3101		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(d) The facility reported a census of 16 residents. The sample included three residents. Based on interview and record review for two of three sampled (#130 and #131), the Operator failed to ensure the negotiated service agreement (NSA) contained the name of the licensed nurse responsible for the implementation and supervision of the health service plan. Findings included: - Record review for Resident #130 recorded admission date of 8/26/19 with diagnoses of traumatic brain injury, dysphagia, Schizophrenia,	S3165		

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S3165	Continued From page 7 and alcohol abuse. Functional Capacity Screen dated 8/26/19 assessed #130 unable to perform (3) bathing, dressing, and management of medications and treatments. Resident required physical assistance (2) with toileting, transfer, walk/mobility, and eating. NSA of 8/26/19 documented facility staff to provide services to meet these identified needs. The NSA of 8/26/19 lacked the name of the nurse responsible for the implementation of the health care service plan. - Record review for Resident #131 recorded admission date of 9/2/19 with diagnosis of Alzheimer's. Functional Capacity Screen dated 9/2/19 assessed Resident required physical assistance (2) with bathing, toileting, transfer, walk/mobility and unable to perform (3) dressing and management of medications and treatments. NSA of 9/02/19 documented facility staff to provide services to meet these identified needs. The NSA of 9/02/19 lacked the name of the nurse responsible for the implementation of the health care service plan. On 12/10/19 at 3:00 PM Operator/Registered Nurse #A confirmed the health care service plans for #130 and #131 lacked the signature of the nurse responsible. For Residents #130 and #131, the Operator failed to ensure the NSA contained the name of the licensed nurse responsible for the implementation	S3165		

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S3165	Continued From page 8 and supervision of the health service plan.	S3165		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(3) The census equaled 16 Residents, the sample included three. The Resident Roster identified all Residents of facility as receiving facility management of medications. Based on observations and interview, for one of three sampled (#130) and seven non-sampled (#120, #121, #122, #123, #124, #125, and #126), the Operator failed to ensure licensed nurses or pharmacists placed the full name of Resident on each package of the Resident's over the counter medication. Findings included:	S3211		

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S3211	Continued From page 9 - Observation on 12/09/19 at 12:31 PM revealed a locked medication closet in the living/dining area of the facility. The closet contained purple bins, a separate bin for each Resident's medications. The following medications were without first and last names: One tube Arthricream rub (topical pain reliever) and one bottle of Milk of Magnesia (laxative) in the bin for #120 Bottle of Benadryl (allergy) tablets and bottle of Aspirin (cardiac protection) 81mg (milligrams) tablets in bin for #121 Bottle of Sentry multivitamins and bottle of Melatonin (sleep) tablets in bin for #122 Bottle of Antacid (reflux or indigestion) tablets in bin for #123, Box of Laxative tablets in bin for #124 Three bottles of Timolol (prescription for glaucoma) eye drops with no name or label in bin for #125 Bottle of Vitamin C (supplement) 500mg tablets, bottle of Acetaminophen (pain/fever) tablets, and three sleeves of Dulcolax (laxative) tablets in bin for #130 Bottle of Milk of Magnesia in bin for #126 On 12/09/19 at approximately 1:02 PM Operator/Registered nurse #A stated these medications are waiting to be added to the medication cart... was not aware that each medication had to have first and last name on them in the closet as well... The Operator failed to ensure licensed nurses or pharmacists placed the full name of Resident on each package of the Resident's over the counter medication.	S3211		