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	N059017	A. BUILDING: _____ B. WING _____	R 03/21/2018

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 Special Revisit at the above named facility in McPherson, Kansas on 3/19/18, 3/20/18, and 3/21/18. Revised 2567 to facility 4/2/2018.	{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)(1-2) The census equalled 15 the sample included three Residents. The Resident roster identified all 15 Residents with facility managed medications. Based on observation, interview, and review of records, for two of three sampled Residents (#1086 and #1064), the Operator failed to ensure	S3200		

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

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S3200	Continued From page 1 all medications and biologicals administered to each Resident in accordance with professional standards, in accordance with each manufacturer's recommendations, and in accordance with written medical care provider orders. Findings included: - Review of record revealed #1086 admitted to facility 02/06/15 with diagnoses of congestive heart failure, atrial fibrillation, and hypertension. Functional capacity screen of 02/09/18 assessed #1086 unable to perform medication and treatment management. The 02/09/18 negotiated service agreement documented facility staff to provide medication and treatment management. Comparison of the March 2018 MAR (medication administration record) with written, signed, physician's orders revealed a discrepancy. The signed physician's orders dated 01/02/18 included "DSS 100 plus one tab PO (by mouth) PRN (as needed). The March 2018 MAR lacked this order. On 3/19/18 at 6:10pm facility nurse #F stated I removed the DSS 100 order when I reviewed and prepared the March Mars... since it is the same as the "Senekot S PRN" I took the DSS off to kind of clean up the MAR... facility nurse #F confirmed no physician's order obtained to remove the medication in accordance with standards of practice. The Operator failed to ensure all medications administered to #1086 in accordance with professional standards of practice and in	S3200		

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S3200	Continued From page 2 accordance with written physician's orders. - Review of record revealed #1064 admitted 02/01/18 with diagnoses of congestive heart failure, chronic obstructive pulmonary disease, peripheral vascular disease, hypertension, and wound to left leg. Functional capacity screen of 02/01/18 assessed #1064 unable to perform medication and treatment management. The 02/01/18 negotiated service agreement documented facility staff to provide medication and treatment management. Comparison of the March 2018 MAR (medication administration record) with written, signed, physician's orders revealed a discrepancy. The signed physician's orders dated 02/28/18 included "Metolazone 5mg (milligrams) "1" tab PO (by mouth) daily. The March 2018 MAR recorded Metolazone 5mg "2" tab PO daily, also dated 02/28/18. By observation, in the medication storage cart, on 3/19/18 at 6:20pm, the Metolazone prescription bottle label for #1064 documented "Metolozone 2.5mg take two tablets on Thursday, Friday, Saturday... On 3/19/18 at 6:20pm facility nurse #F confirmed the medication prescription label and the March 2017 MAR did not match the signed physician's order... stated I did not change the MAR to read "2" tablets... whoever changed the MAR did so in error because the tablets with dose of 2.5mg does not match the ordered dose of one 5mg... The Operator failed to ensure all medications administered to #1064 in accordance with	S3200		

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S3200	Continued From page 3 professional standards of practice and in accordance with written physician's orders.	S3200		
{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 equalled 15 the sample included three Residents. The Resident roster identified all 15 Residents with facility managed medications. Based on observations and interview, for two of three sampled Residents (#1086 and #1064) and six non sampled (#1078, #1052, #1054, #1056, #1085, and #1058), the Operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the Resident on each accepted original, unbroken manufacturer's package of over-the-counter (OTC) medication for Resident administration.	{S3211}		

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{S3211}	Continued From page 4 Findings included: - By observation on 3/19/18 at 5:00pm, in review of the medication cart of facility, the following noted: #1078 - brown plastic bottle with white lid scotch tape on the side with black marker hand writing ""furosemide 2 tabs daily"; bottle of Nystop powder, no RX (prescription) label, no name; Cranberry extract 450mg (milligrams with first name only; #1086- bottle of "stool softener plus stim lax" with no name; #1074 - bottle of vitamin B12 1000mg with no name; #1054 - bottle Vitamin D3 1000 IU (international units) with first name only; bottle Folic acid with initials only; bottle Colace 100mg with first name only #1056 - bottle of Senna S with first name only; bottle Aspirin 81mg with no name #1085 - Bottle of 500 tablets acetaminophen 500mg initials only; bottle Vitamin C 500mg with initials only; bottle "Stool Softener" with initials only; bottle Melatonin 3mg with no name; bottle Calcium 500mg with initials only; Bottle Vitamin B1 with initials only; bottle aspirin 81mg with no name #1087 - bottle milk of magnesia with no name, initials only On 3/19/18 at 6:00pm certified staff #A confirmed the medications in the various areas of the	{S3211}		

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{S3211}	Continued From page 5 medication cart belonged to the persons indicated above... confirmed these containers of medications lacked the first and last name of the Resident. The Operator failed to ensure the licensed nurse or licensed pharmacist placed the first and last names of #1078, #1086, #1074, #1054, #1056, #1085, and #1087, on each accepted, original, unbroken manufacturer's package of OTC medication for Resident administration.	{S3211}		
{S3215} SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as	{S3215}		

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{S3215}	Continued From page 6 recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)(4) The census equalled 15 the sample included three Residents. The Resident roster identified all 15 Residents with facility managed medications. Based on observations and interview, for three non-sampled Residents with expired over the counter medications (#1078, #1074, and #1054), the Operator failed to ensure licensed nurse or medication aide did not administer medication beyond the manufacturer's recommended date of expiration. Findings included: - By observation on 3/19/18 at 5:00pm, in review of the medication cart of facility, the following noted: #1078 - Bottle of Nystop (anti fungal) skin treatment - expired 10/2017; Athlete's foot cream 1% (anti fungal) skin treatment - expired 08/2017 #1074 - nearly full bottle of L-thyroxine (thyroid therapy), initial content of 75 tablets, expired 02/21/18; #1054 - bottle of multivitamins expired august	{S3215}		

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{S3215}	Continued From page 7 2017 On 3/19/18 at 6:00pm certified staff #A confirmed the medication packages listed above contained expiration dates that had already passed but medications still stored in the Residents' medication bins... For #1078, #1054, and #1074, the Operator failed to ensure licensed nurse or medication aide did not administer medication beyond the manufacturer's recommended date of expiration.	{S3215}		
S3216 SS=F	26-41-205 (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 facility 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.	S3216		

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S3216	Continued From page 8 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(i) The census equalled 15 the sample included three Residents. The Resident roster identified all Residents as receiving medication management. Based on observation, interviews and reviews of records, for one of three sampled (#1064), one non-sampled (#1085), and all Residents with medication management, the Licensed nurses and Medication aides failed to maintain records of receipt and disposition of medications in sufficient detail for an accurate reconciliation according to acceptable standards of practice. Findings included: The roster identified all Residents as receiving facility management of medications. - Review of record revealed #1064 admitted 02/01/18 with diagnoses of congestive heart failure, chronic obstructive pulmonary disease, peripheral vascular disease, hypertension, and wound to left leg. Functional capacity screen of 02/01/18 assessed #1064 unable to perform medication and treatment management. The 02/01/18 negotiated service agreement documented facility staff to provide medication and treatment management. Medication cart review on 3/19/18 at 5:00pm with certified staff #A revealed a bottle of Metolazone 2.5mg (milligrams). The label directed "take one tablet Thursday, Friday, Saturday"... filled on	S3216		

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S3216	Continued From page 9 11/22/17, a hand written note added to label "one tablet Tuesday/Friday." Two tablets remained in the bottle. On 3/19/18 at 6:05pm, Operator #G and facility nurse #F stated no method used to track date first medication from container administered, or how many doses brought into facility and when. Comparison of the March 2018 MAR (medication administration record) with written, signed, physician's order revealed the discrepancy of one versus two tablets of Metolazone given daily (signed order recorded one tablet, MAR recorded two tablets). By additional observation, in the medication storage cart, on 3/19/18 at 6:20pm, the Metolazone prescription bottle label for #1064 documented "Metolozone 2.5mg take two tablets on Thursday, Friday, Saturday... prescription filled 11/22/17. Operator #G and facility nurse #F confirmed two tablets remained... not sure why bottle not already empty but not sure what day we started using this bottle... stated he/she may have brought in several bottles at time of admission (02/01/18)... no way of knowing how many brought or when this bottle started... we do not keep receipts... we do not count doses when bottles brought in from home... we have no system of accounting for medications... Licensed nurses and medication aides failed to maintain records of receipt and disposition of medications for #1064 and for all Residents in sufficient detail for an accurate reconciliation. - Additional medication cart review of non-sampled Resident #1085 revealed:	S3216		

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S3216	Continued From page 10 Bottle of Sertraline (prescription depression medication) filled on 3/05/18, thirty tablets dispensed. The bottle contained seven and one half tablets. Physician order documented one and one half tablets administered daily at 8:00am. Bottle of Lisinopril (blood pressure medication) filled on 12/21/17, thirty tablets dispensed. The bottle contained seven tablets. Physician order documented one half tablet administered daily. By interview on 3/19/18 at 6:05pm, Operator #G and facility nurse #F confirmed no method used to determine date first dose of medication administered from these bottles after delivery, and how many doses of medication brought to facility by Resident from home. License nurses and medication aides failed to maintain records of receipt and disposition of medications for #1085 and for all Residents in sufficient detail for an accurate reconciliation.	S3216		
{S3250} SS=E	26-41-105 (a) Resident Records a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the maintenance of a record for each resident in accordance with accepted professional standards and practices. (1) Designated staff shall maintain the record of each discharged resident who is 18 years of age or older for at least five years after the discharge of the resident. (2) Designated staff shall maintain the record of each discharged resident who is less than 18 years of age for at least five years after the resident reaches 18 years of age or at least five	{S3250}		

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{S3250}	Continued From page 11 years after the date of discharge, whichever time period is longer. This REQUIREMENT is not met as evidenced by: KAR 26-41-105(a) The census equalled 15 the sample included three Residents. Based on interview and review of record, for three of three sampled (#1086 and #1062), the Operator failed to ensure the maintenance of a record for each Resident in accordance with accepted professional standards and practices. Findings included: - Review of record revealed #1086 admitted to facility 02/06/15 with diagnoses of congestive heart failure, atrial fibrillation, and hypertension. Functional capacity screen of 02/09/18 assessed #1086 in need of physical assistance with bathing, dressing, toileting, transfers, mobility, and eating; unable to perform medication and treatment management; with bladder incontinence; with short term memory, memory recall, and decision making impairments; used a walker and a wheelchair. The 02/09/18 negotiated service agreement (NSA) documented staff to assist Resident with these identified needs. The medical record clinical notes recorded "01/22/18 - 3:00pm - fall on Saturday evening... taken to emergency room due to low blood	{S3250}		

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{S3250}	Continued From page 12	{S3250}		

pressure and rib pain..."
Emergency room discharge notes included home instructions for "contusions" and for "neuro checks" to be done every shift.
Physician appointment notes of 01/25/18 documented "resolving hematoma right periorbital (eye) area..."
The medical record lacked an assessment of the "contusion" or injury to #1086's eye area, to include location, size, color, drainage/open/closed description in accordance with standards of practice.
The medical record lacked documentation of neuro checks.
The medical record lacked documentation of investigative steps taken to determine the time, location, circumstances, and potential causal factors of Resident's falls.
The medical record lacked documentation of last time Resident observed/assisted prior to discovery of fall, and lacked review of length of time Resident waited after calling for assistance and then proceeding independently.

On 3/19/18 at 7:00pm facility nurse provided "Neurological Assessment Flowsheet." This page lacked documentation of a date, of the time checks completed, and lacked identifying signature or initials of who completed the checks. Hand written note at the top of page "fill out only if instructed to by licensed nurse" but no indication a licensed nurse completed pupil reaction assessment in accordance with standards of practice. The record lacked evidence the physician notified no licensed staff on duty to complete neuro checks every shift.

The medical record clinical notes recorded a "scab area on heel." The medical record lacked an assessment of the "scab area" to include

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{S3250}	Continued From page 13 location, color, size, tenderness... in accordance with standards of practice. On 3/19/18 at 6:00pm facility nurse #F stated certified staff do the neuro checks... they did not initial them... #F confirmed no documented assessment of eye injury on 01/20/18 and of heel scab area 3/01/18. The Operator failed to ensure the maintenance of a record for #1086 in accordance with accepted professional standards and practices. - Review of record revealed #1062 admitted to facility 3/02/18 with diagnoses of hypertension, depression, weakness, post femur fracture, and stage III pressure ulcer right buttock. Functional capacity screen of 3/01/18 assessed #1062 in need of physical assistance with bathing, dressing, toileting, transfers; in need of supervision with mobility and eating; unable to perform medication and treatment management; with bladder incontinence; with short term memory, memory recall, and decision making impairments; used a walker and a wheelchair. The 3/01/18 negotiated service agreement (NSA) documented staff to assist Resident with these identified needs. Admission nursing assessment of 3/01/18 recorded stage III pressure ulcer. The record lacked an assessment of the pressure ulcer, lacked a health service plan to include pressure ulcer interventions by staff, and lacked progress notes to describe ongoing assessment of progress/healing or decline in the area.	{S3250}		

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{S3250}	Continued From page 14 On 3/19/18 at 6:50pm facility nurse #F confirmed I do not have any assessment notes at time of admission or since then... we did not develop a plan, were to help him/her with changing at toilet time... the area is closed at this time... The Operator failed to ensure the maintenance of a record for #1062 in accordance with accepted professional standards and practices.	{S3250}		