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	N059017	A. BUILDING: _____ B. WING _____	C 01/17/2018

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

(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 Residential Health Care Facility in McPherson, Kansas on 01/10/18, 01/11/18, 01/16/18, and 01/17/18. Complaint #114791 also investigated.	S 000		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a) The census equalled 14 the sample included three Residents with four focused reviews. Based on interview and review of record, for one of three sampled (#189), the Operator failed to ensure designated facility staff completed a functional capacity screen (FCS) on or before that individual admitted to facility. Findings included:	S3080		

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

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S3080	Continued From page 1 - Review of record revealed #189 admitted to facility 01/05/17 with diagnoses of congestive heart failure and Alzheimer's. The record lacked a FCS completed at the time of admission to this facility. The record contained a FCS completed at another admission to a previous facility. The FCS of the record dated 12/22/17 completed the day after admission to that facility on 12/21/17. The FCS of the previous facility record indicated #189 needed physical assistance with bathing, dressing, toileting, transfers, mobility; Resident unable to perform medication and treatment management, with occasional bladder incontinence, with memory recall impairment, with falls/unsteadiness; with vision and hearing impairments and used a walker. The current negotiated service agreement (NSA) completed 01/05/18 at time of admission to this facility recorded interventions to address physical assistance with the activities of daily living described above. On 01/10/18 at 2:15pm facility nurse #F and Operator #G confirmed no FCS completed at time of admission to this facility. The Operator failed to ensure designated facility staff completed a FCS at time of admission to the facility for #189.	S3080		
S3156 SS=D	26-41-204 (b) Health Care Services (b) If the functional capacity screening indicates that a resident is in need of health care services, a licensed nurse, in collaboration with the	S3156		

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S3156	Continued From page 2	S3156		

resident, the resident ' s legal representative, the case manager, and, if agreed to by the resident or resident ' s legal representative, the resident ' s family, shall develop a health care service plan to be included as part of the negotiated service agreement.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-204(b)

The census equalled 14 the sample included three Residents with four focused reviews. Based on interview and review of record, for one of three sampled (#189), the Operator failed to ensure a licensed nurse developed a health care service plan (HSP) as a part of the negotiated service agreement when a Resident admitted with identified health care needs.

Findings included:

- Review of record revealed #189 admitted to facility 01/05/17 with diagnoses of congestive heart failure and Alzheimer's.

The record lacked a functional capacity screen (FCS) completed at the time of admission to this facility. The record contained a FCS completed at another admission to a previous facility. The FCS of the record dated 12/22/17 completed the day after admission to that facility on 12/21/17.
The FCS of the previous facility record indicated #189 needed physical assistance with bathing, dressing, toileting, transfers, mobility; Resident unable to perform medication and treatment

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S3156	Continued From page 3 management, with occasional bladder incontinence, with memory recall impairment, with falls/unsteadiness; with vision and hearing impairments and used a walker. The current negotiated service agreement (NSA) completed 01/05/18 at time of admission to this facility recorded interventions to address physical assistance with the activities of daily living described above. the record lacked a health service plan completed at the time of admission as part of the NSA. On 01/10/18 at 2:15pm facility nurse #F and Operator #G confirmed #189 in need of health services and assistance with activities of daily living with no HSP completed at time of admission to this facility. The Operator failed to ensure designated facility staff completed an HSP at time of admission to the facility for #189.	S3156		
S3165 SS=D	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 26-41-204(d) The census equalled 14 the sample included three Residents with four focused reviews. Based	S3165		

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S3165	Continued From page 4 on interview and review of record, for one of three sampled (#189), the Operator failed to ensure the negotiated service agreement (NSA) contained a description of the services to be provided, and the name of the licensed nurse responsible for the implementation and supervision of the health service plan (HSP). Findings included: - Review of record revealed #189 admitted to facility 01/05/17 with diagnoses of congestive heart failure and Alzheimer's. The record lacked a functional capacity screen (FCS) completed at the time of admission to this facility. The record contained a FCS completed at another admission to a previous facility. The FCS of the record dated 12/22/17 completed the day after admission to that facility on 12/21/17. The FCS of the previous facility record indicated #189 needed physical assistance with bathing, dressing, toileting, transfers, mobility; Resident unable to perform medication and treatment management, with occasional bladder incontinence, with memory recall impairment, with falls/unsteadiness; with vision and hearing impairments and used a walker. The current negotiated service agreement (NSA) completed 01/05/18 at time of admission to this facility recorded interventions to address physical assistance with the activities of daily living described above. The record lacked a health service plan completed at the time of admission as part of the NSA. A physician signed hospital discharge order dated 12/21/17 directed to weigh every other day and	S3165		

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S3165	Continued From page 5 alert physician if weight increases more than two pounds. This service not included in the NSA. A 12/22/17 home health certification plan of care in the record documented #189 to have a mechanical soft diet. This service not included in the NSA. Although physical assistance needed with transfers identified on the FCS, the NSA lacked a service to meet this need. The record contained a physician's order for PT (physical therapy) and OT (occupational therapy) dated 12/21/17. The NSA contained PT but did not include OT and record lacked documentation this order discontinued. The NSA lacked the name of the licensed nurse responsible for the health care needs of #189. The space for this name remained blank. On 01/10/18 at 3:00pm facility nurse #F and Operator #G confirmed the NSA lacked a description of these services and the name of the nurse responsible for health care services in this facility. The Operator failed to ensure the NSA for #189 contained the name of the licensed nurse responsible for the implementation and supervision of the HSP.	S3165		
S3201 SS=D	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally	S3201		

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S3201	Continued From page 6	S3201		

prepared;
(B) identify the resident before medication is administered;
(C) remain with the resident until the medication is ingested or applied; and
(D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-205(d)(3)

The census equalled 14 the sample included three Residents with four focused reviews completed. The Resident roster identified all 14 Residents with facility managed medications. Based on observation, review of record, and interview, for one of three sampled (#189), the Operator failed to ensure an actual clock time documented for medications on the MAR (medication administration record) with only time intervals or events for administration.

Findings included:

- Review of record revealed #189 admitted to facility 01/05/17 with diagnoses of congestive heart failure and Alzheimer's.

The record lacked a FCS completed at the time of admission to this facility. The record contained

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S3201	Continued From page 7	S3201		

a FCS completed at another admission to a previous facility on 12/21/17.
The FCS of the previous facility record indicated #189 unable to perform medication and treatment management.

The current negotiated service agreement (NSA) completed 01/05/18 at time of admission to this facility recorded interventions to address medication management by the facility.

Review of the medication administration record (MAR) for January 2018 revealed the MAR initiated on 01/01/18, although Resident admitted in this facility 01/05/18.
The administration times for medications and biologicals documented as "AM" (morning) and "HS" (bedtime). The MAR lacked documentation of the time the medications actually administered to #189 as required.
The MAR's contained the following medications:

Simvastatin (cholesterol lowering) 20mg (milligrams) daily - "HS"
Fish oil (supplement) 1000mg daily - "AM"
Vitamin B12 (supplement) 1000mcg (micrograms) daily - "AM"
Glucosamine (joint supplement) 500mg one every 12 hours - "AM" and "HS"
Allopurinol (for gout or kidney stones) 100mg two daily - "AM"
Lisinopril/HCTZ (blood pressure) 20/25mg daily - "AM"
Multi vitamin (supplement) daily - "AM"
Amlodapine besylate (blood pressure) 4mg daily - "AM"
Aspirin (cardiac protection) 81mg daily - "AM"
Myrbetriq (overactive bladder) 25mg one daily - "AM"
Raloxifine (osteoporosis) 60mg one daily - "AM"

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S3201	Continued From page 8 On 01/10/18 at 3:10pm facility nurse #F and Operator #G confirmed the MAR contained administration of medications initialed before Resident's admission... confirmed this MAR lacked specific times the medications administered... facility nurse #F stated not sure why no specific times on medication administrations... For #189 the Operator failed to ensure an actual clock time documented for medications on the MAR.	S3201		
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 14 the sample included three Residents with four focused reviews	S3211		

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S3211	Continued From page 9	S3211		

completed. The Resident roster identified all 14 Residents with facility managed medications. Based on observations and interview, for two of three sampled Residents (#187 and #185) and four non sampled (#178, #176, #174, and #172), 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.

Findings included:

- By observation on 01/11/18 at 3:31pm, in review of the medication cart of facility, the following noted:

#178 - bottles of Centrum multivitamin, aspirin, and calcium with a first name, no last name of Resident.

#176 - bottle of aspirin with no name located in #176's "area" of the medication drawer

#174 - bottles of folic acid, vitamin D3, cranberry tablets, multi vitamins, and stool softener located in #174's "area" of the medication drawer, no first or last name of Resident on bottles

#185 - bottles of calcium, vitamin B1, melatonin with no name; Centrum vitamins, vitamin C, acetaminophen, and aspirin with initials only in #185's "area" of the medication drawer

#187 - bottle of stool softener with no name in #187's "area" of the medication drawer

#172 - bottles of loratadine, aspirin, and vitamin D3 with no name in #172's "area" of the medication drawer

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S3211	Continued From page 10 On 01/11/18 at 3:31pm certified staff #A confirmed the medications in the various areas of the 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 #178, #176, #174, #185, #187, and #172, 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	S3215		

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S3215	Continued From page 11 aides. (3) Any resident who self-administers medication and is unable to provide proper storage as 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 14 the sample included three Residents with four focused reviews completed. The Resident roster identified all 14 Residents with facility managed medications. Based on observations and interview, for one of two non-sampled Residents with expired over the counter medications, the Operator failed to ensure licensed nurse or medication did not administer medication beyond the manufacturer's recommended date of expiration. Findings included: - By observation on 01/11/18 at 3:31pm, in review of the medication cart of facility, the following noted: #188 - Bottle of Nystop (anti fungal) skin treatment - expired 10/2017. #178 - Athlete's foot cream 1% (anti fungal) skin treatment - expired 08/2017	S3215		

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S3215	Continued From page 12 #176 - Calcium 600mg (milligrams) tablets, bottle nearly full, expired 02/2006 #174 - Bottle of multi vitamins expired 08/2017, bottle of stool softener expired 09/2016; observed a nearly full bottle of L-thyroxine (thyroid therapy), initial content of 75 tablets, labeled to expire in February 2018. #186 - bottle of Warfarin (prescription blood thinner) expired 01/05/18 On 01/11/18 at 3:31pm certified staff #A confirmed the medication packages listed above contained expiration dates that had already passed... #A stated not sure of the facility process for expired medication surveillance. For #188, #178, #176, #174, and #186, the Operator failed to ensure licensed nurse or medication did not administer medication beyond the manufacturer's recommended date of expiration.	S3215		
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 13 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 14 the sample included three Residents with four focused reviews. Based on interview and review of record, for three of three sampled (#189, #187, and #185) and for three focused reviews (#180, #182, and #184), 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 #189 admitted to facility 01/05/17 with diagnoses of congestive heart failure and Alzheimer's. The record lacked a functional capacity screen (FCS) completed at the time of admission to this facility. The record contained a FCS completed at time of admission to a previous facility. The FCS of the record dated 12/22/17 completed the day after admission to that facility on 12/21/17. The FCS of the previous facility record indicated #189 needed physical assistance with bathing, dressing, toileting, transfers, mobility; Resident unable to perform medication and treatment management, with occasional bladder incontinence, with memory recall impairment, with falls/unsteadiness; with vision and hearing	S3250		

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S3250	Continued From page 14	S3250		

impairments and used a walker.

The current negotiated service agreement (NSA) completed 01/05/18 at time of admission to this facility recorded interventions to address physical assistance with the activities of daily living described above.
The record lacked a health service plan completed at the time of admission as part of the NSA.

The medical record contained one interdisciplinary progress (IDP) note (move into facility) since admission on 01/05/18.
This admission IDP note lacked a time in accordance with accepted professional standards of practice.
The note and the medical record lacked an admission assessment of Resident's physical, cognitive, medical, and emotional status of Resident at time of admission also in accordance with standards of practice.

On 01/10/18 at 2:15pm, 3:00pm, and 3:10pm, facility nurse #F and Operator #G confirmed the medical record lacked the the time and details of the admission assessment/process.

The Operator failed to ensure the maintenance of a record for #189 in accordance with accepted professional standards and practices.

- Review of record revealed #187 admitted to facility 11/01/16 with Parkinson, dementia, Lewy body, atrial fibrillation, and autonomic instability.

The current functional capacity screen (FCS) of 10/13/17 assessed #187 in need of physical assistance with bathing, dressing, toileting,

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	N059017	A. BUILDING: _____ B. WING _____	C 01/17/2018

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

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transfers, mobility; unable to perform medication and treatment management; incontinent of bowel and bladder; with short term memory, memory recall and decision making impairments; used walker and wheelchair.

The current NSA documented staff to assist Resident with these identified needs.

The medical record clinical notes of the record included 6/29/17 to 11/09/17. The entries all lacked a time in accordance with professional standards of practice. Entries prior to this time were not available for this review.
A 7/28/17 entry recorded "fall in bathroom non injury." The record lacked additional information to include time, location, pre-emptive symptoms or activities, staff response and/or treatment, assessment information, persons contacted, and other pertinent details in accordance with professional standards of practice.

On 01/10/18 at 4:08pm facility nurse #F and Operator #G confirmed no other documentation available regarding fall in July.

The Operator failed to ensure the maintenance of a record for #187 in accordance with accepted professional standards and practices.

- Review of record revealed #185 admitted to facility 02/17/17 with diagnoses of dementia, hypertension, and fracture of right leg.

The current functional capacity screen (FCS) of 02/17/17 assessed #185 in need of physical assistance with bathing, dressing, toileting, transfers, and mobility; unable to perform medication and treatment management, with

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short term memory, long term memory, memory recall, and decision making impairments; with falls/unsteadiness; used walker and wheel chair.

The current NSA documented staff to assist Resident with these identified needs.

The medical record clinical notes of the record included 7/05/17 to 12/18/17. The entries all lacked a time in accordance with professional standards of practice. Entries prior to this time were not available for this review.

By observation on 01/10/18 during entrance tour of facility, #185 with bruising to right side of face, cheek, and jaw. Facility staff confirmed #185 with a recent fall and visit to the emergency room on 01/02/18.
The medical record lacked any documentation of this incident in accordance with professional standards of practice.

On 01/11/18 at 1:15pm facility nurse #F confirmed no other documentation available in the Resident's record... stated there may be documentation in the home health record... perhaps some type of admission note in home health... but no documentation in record regarding recent fall, treatment, or interventions since the fall.

The Operator failed to ensure the maintenance of a record for #185 in accordance with accepted professional standards and practices.

- Review of record revealed #184 admitted to facility 12/01/17 with diagnoses of insomnia, depression, atrial fibrillation, history of stroke, and arteriosclerotic heart disease.

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S3250	Continued From page 17 The current functional capacity screen (FCS) of 12/04/17 assessed #184 independent with activities of daily living, with short term memory, long term memory, memory recall, and decision making impairments. The current negotiated service agreement recorded staff to assist with medications and cares as needed. Interview of Operator #G on 01/11/18 at 3:30pm revealed #184 left facility unknown by staff and returned by police department after a neighbor intercepted #184 while walking outside. Operator #G described the investigative and reporting process, partially completed and still in progress. By review, the medical record lacked any documentation of this incident. By review the record lacked any "nurses notes" "interdisciplinary notes", or "clinical notes" to describe this event and responsive actions, in accordance with professional standards of practice. Operator #G confirmed no documentation in the record. The Operator failed to ensure the maintenance of a record for #184 in accordance with accepted professional standards and practices. - Review of record revealed #182 admitted to facility 5/26/15 with Alzheimer's dementia. The functional capacity screen and negotiated service agreement of 5/26/17 assessed #182 in need of assistance with activities of daily living, with facility staff to provide assistance as needed. Medical record documentation in clinical notes of 8/07/17 (no time) described #182 left the facility	S3250		

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S3250	Continued From page 18 unknown to staff the evening of 8/07/17, and was returned after emergency staff transported #182 to the hospital for evaluation. On 01/11/18 at 3:30pm Operator #G described the investigative process and corrective steps after this incident. Operator confirmed this information not included in the clinical notes. The next entry of clinical notes dated 10/09/17 (no time) documented "#182 was complaining of groin pain, shaking unable to stand this morning. Notified Dr. who requested to see him/her. Dr. removed large amount of stool and ordered magnesium citrate (laxative) and stool softener. Family brought meds in. Clinical note 10/11/17 - no time - received report from Dr. #182 has a fractured pelvis, orders received. Operator attempted to call family... The clinical notes lacked evidence of any assessment of #182, and lacked documentation of investigative steps taken to determine the cause of the pelvic fracture. The clinical notes lacked documentation of corrective actions or follow-up care received by #182 as the result of the pelvic fracture, and any changes in care needs as the result of this diagnosis. The Operator failed to ensure the maintenance of a record for #182 in accordance with accepted professional standards and practices. - Review of record revealed #180 admitted to facility 3/31/17 with diagnoses of urinary tract infection and confusion. The functional capacity screen and negotiated	S3250		

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S3250	Continued From page 19 service agreement of 3/31/17 documented the need for physical assistance with activities of daily living, and that facility staff to provide services to meet those needs. The medical record lacked nurses notes, clinical notes, or interdisciplinary notes. The record lacked an assessment of #180 at time of admission, the date and time arrived, and general status at time of admission. The record lacked documentation of care and events that evolved after the admission process completed. Current facility staff able to locate by computer a page of typed notes by the previous facility nurse/Operator. These notes described the receipt of physician orders and "waiting for urinalysis results" on 4/01/17. These notes also described an order for an antibiotic (Levaquin) initiated on 4/03/17. The final note described the discharge of #180 on 4/09/17 by request of family member. The medical record lacked documentation in accordance with professional standards of practice. The Operator failed to ensure the maintenance of a record for #180 in accordance with accepted professional standards and practices.	S3250		