STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087082	A. BUILDING: _____ B. WING _____	11/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOVE ESTATES SENIOR LIVING COMMUNITY	1400 S 183RD WEST GODDARD, KS 67052

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with investigation of complaints #97660 and #101380 of the above assisted living facility on 11/14/16, 11/16/16, 11/17/16, 11/21/16, 11/22/16, and 11/23/16.	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.	S3028		

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

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed records reviewed. Based on record review and interview for 2 (#520 and #524) of 6 residents sampled, the administrator failed to report potential allegations of abuse and/or neglect to the department within 24 hours of each incident. Findings included: - Record review for resident #520 revealed an admission date of 9/30/16 and diagnoses of chronic atrial fibrillation and benign neoplasm of meninges. The admission functional capacity screen dated 9/30/16 indicated the resident required supervision with toileting and transferring; physical assistance with walking; experienced impaired short-term memory, decision making, and memory recall; utilized a walker or wheelchair for mobility; and was at risk for falls. The health care service plan dated 9/30/16 documented one-person assistance with gait belt to ambulate with resident or mobilize resident in wheelchair; supervise transfers for resident safety; and reminders and cueing due to resident's impaired cognition. In the health care service plan section for "current or recent problems and risks falls, unsteadiness" director of nursing B documented interventions of personal call pendant and encourage supervision with ambulation. Review of the progress notes revealed the	S3028		

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S3028	Continued From page 2 following documentation by licensed nurses: 9:24 p.m. on 10/30/16 resident used call pendant. Resident found on floor next to bed. Resident stated he/she did not fall but could not explain how he/she got to the floor. 10:52 p.m. on 10/30/16 resident used call pendant and resident found again on floor next to bed. Resident again stated he/she did not fall. Resident denied head contact but there was an abrasion to right forehead. Encouraged resident to use pendant when needing to ambulate. At 1:35 p.m. on 11/22/16, director of nursing B stated these incidents were not reported to the department. For resident #520, the administrator failed to report potential allegations of abuse and/or neglect to the department within 24 hours of each incident. - Record review for resident #524 revealed an admission date of 2/3/15 and diagnoses of dementia and atrial fibrillation. The record contained a functional capacity screen 1/28/16 that indicated the resident was independent with toileting and transferring; required supervision with walking; experienced impaired short-term memory, decision making, and memory recall; utilized a walker for mobility; and was at risk for falls. The health care service plan dated 1/28/16 documented services of supervision with mobility due to unsteady gait. The progress notes contained an entry by a	S3028		

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S3028	Continued From page 3 licensed nurse at 7:06 a.m. on 8/20/16 that resident had unwitnessed fall at 5:15 a.m. The licensed nurse documented resident was up and dressed for the day at midnight, resident reoriented and resident went back to bed. "Due to resident's condition it is unknown exactly what happened during fall." At 1:35 p.m. on 11/22/16, director of nursing B stated this incident was not reported to the department. For resident #524, the administrator failed to report a potential allegation of abuse and/or neglect to the department within 24 hours of the incident.	S3028		
S3095 SS=E	26-41-202 (f) NSA Refusal of Service (f) If a resident or the resident's legal representative refuses a service that the administrator or operator, the licensed nurse, the resident's medical care provider, or the case manager believes is necessary for the resident's health and safety, the negotiated service agreement shall include the following: (1) The service or services refused; (2) identification of any potential negative outcomes for the resident if the service or services are not provided; (3) evidence of the provision of education to the resident or the resident ' s legal representative of the potential risk of any negative outcomes if the service or services are not provided; and (4) an indication of acceptance by the resident or the resident's legal representative of the potential risk. .	S3095		

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S3095	Continued From page 4 This REQUIREMENT is not met as evidenced by: KAR 26-41-202(f)(1)(2)(3)(4) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed records reviewed. Based on record review and interview for 2 (#525 and #522) of 6 residents sampled, the administrator failed to ensure each resident's negotiated service agreement (NSA) included the service or services refused; identification of any potential negative outcomes for the resident if the service or services were not provided; evidence of the provision of education to the resident of the potential risk of any negative outcomes if the service or services were not provided; and an indication of acceptance by the resident of the potential risk. Findings included: - Record review for resident #525 revealed an admission date of 7/12/14 and diagnoses of kidney failure, unspecified dementia, and muscle weakness. The functional capacity screen dated 6/26/16 indicated the resident was independent with toileting, transferring, and mobility; experienced impaired short-term memory and memory recall; utilized a walker for mobility; and was at risk for falls. The health care service plan dated 6/26/16 documented resident unsteady with ambulation, used a walker for mobility, and "requests to walk independently at this time." The health care service plan contained the signature of the resident and director of nursing B.	S3095		

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S3095	Continued From page 5 Review of the progress notes revealed the resident experienced 9 falls from 8/16/15 through 7/15/16 with most falls occurring in the bathroom. During an interview at 12:25 p.m. on 11/17/16 certified medication aide F stated resident was independent with mobility but did encourage resident to use cane or walker. At 3:40 p.m. on 11/17/16 resident stated he/she was independent with all activities of daily living. Resident stated he/she had fallen due to not thinking of what he/she was doing at the time. The resident's record lacked an NSA or a signed refusal of service. At 1:33 p.m. on 11/22/16, director of nursing B confirmed resident would not call for assistance in order to reduce risk for falls and had not signed a refusal of services. The administrator failed to ensure resident #525's NSA included the service or services refused; identification of any potential negative outcomes for the resident if the service or services were not provided; evidence of the provision of education to the resident of the potential risk of any negative outcomes if the service or services were not provided; and an indication of acceptance by the resident of the potential risk. - Record review for resident #522 revealed an admission date of 7/15/15 and a diagnosis of chronic obstructive pulmonary disease. The functional capacity screen dated 6/28/16 indicated the resident required physical assistance with bathing, dressing, toileting,	S3095		

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S3095	Continued From page 6	S3095		

transferring, and mobility; experienced impaired short-term memory and memory recall; utilized a walker or wheelchair for mobility; and was at risk for falls.

The health care service plan dated 6/28/16 included fall interventions of use of call pendant, assess apartment for safety hazards, and offer assistance. Health care service plan included one-person assistance with bathing, dressing, toileting, transferring, and mobility.

Review of the progress notes revealed the resident experienced 16 falls from 10/22/15 through 11/7/16 when either toileting self, doing laundry in apartment, or getting up to get food or drink.

At 12:25 p.m. on 11/17/16 certified medication aide (CMA) F stated resident wanted to do things on resident's terms so staff members did not assist unless resident asked for assistance. CMA F stated he/she did remind resident to call for assistance.

The resident's NSA dated 7/15/15 did not include a refusal of service.

At 1:33 p.m. on 11/22/16 director of nursing B confirmed it was resident's choice to not always ask for assistance with activities of daily living in order to reduce risk for falls. Director of nursing B stated resident had not signed a refusal of services.

The administrator failed to ensure resident #522's NSA included the service or services refused; identification of any potential negative outcomes for the resident if the service or services were not provided; evidence of the provision of education

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S3095	Continued From page 7 to the resident of the potential risk of any negative outcomes if the service or services were not provided; and an indication of acceptance by the resident of the potential risk.	S3095		
S3105 SS=E	26-41-202 (j) Negotiated Service Agreement Outside Resource (j) If a resident's negotiated service agreement includes the use of outside resources, the designated facility staff shall perform the following: (1) Provide the resident, 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, with a list of providers available to provide needed services; (2) assist the resident, if requested, in contacting outside resources for services; and (3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice This REQUIREMENT is not met as evidenced by: KAR 26-41-202(j)(1) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed records reviewed. Based on record review and interview for 3 (#522, #525, and #520) of 3 residents sampled with medical care provider written order for outside resources, the administrator failed to ensure the resident or resident's legal representative received a list of providers available to provide needed services.	S3105		

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S3105	Continued From page 8 Findings included: - Record review for resident #522 revealed an admission date of 7/15/15 and diagnosis of chronic obstructive pulmonary disease. The health care service plan dated 6/28/16 documented the resident received services from an outside provider. - Record review for resident #525 revealed an admission date of 7/12/14 and diagnoses of dementia, muscle weakness, and recurrent falls. The health care service plan dated 6/26/16 documented the resident received services from an outside provider. - Record review for resident #520 revealed an admission date of 9/30/16 and diagnoses of chronic atrial fibrillation and benign neoplasm of meninges. The health care service plan dated 9/30/16 documented the resident received services from an outside provider. At 4:05 p.m. on 11/17/16 when asked how residents were informed of providers available to provide needed services, administrator C stated facility did not educate residents about available providers. The administrator failed to ensure the resident or resident's legal representative received a list of providers available to provide needed services.	S3105		
S3155 SS=G	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health	S3155		

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S3155	Continued From page 9 care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed records reviewed. Based on record review and interview for 1 (#526) of 2 closed records reviewed and 2 (#520, and #524) of 6 residents sampled, the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to address the resident ' s risk for falls identified on the functional capacity screen. Resident #526 experienced a fall that resulted in fracture of the right arm and another fall that resulted in fracture of left hip. Findings included: - Closed record review for resident #526 revealed an admission date of 7/16/15 and diagnoses of type 2 diabetes, hypertension, and hypothyroidism. Admission functional capacity screen dated 7/16/15 indicated resident was independent with transferring and walking; required supervision with toileting; experienced impaired short-term memory and memory recall; utilized a walker for ambulation; and was at risk for falls.	S3155		

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	N087082	A. BUILDING: _____ B. WING _____	11/23/2016

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S3155	Continued From page 10 The admission health care service plan (HCSP) dated 7/16/15 lacked interventions to address the resident's risk for falls. Progress notes contained the following entries by licensed nurses: 3:10 p.m. on 8/23/15 at 8:00 p.m. evening of 8/22/15 resident activated pendant. Staff found resident on floor in living room with walker left in kitchen. Resident stated he/she became dizzy and fell. 8:14 p.m. on 10/20/15 resident found in room on floor in sitting position by recliner. Resident stated he/she did not have walker close by, stood up, took a few steps and fell. The HCSP lacked revision to include interventions to address the resident ' s risk for falls. 12:50 p.m. on 12/16/15 resident found on floor in living room next to television stand. Contusion noted to right cheek. Right arm lying above resident's head and appeared to be broken at elbow and dislocated at shoulder. Right patella appears to be dislocated laterally. Resident stated he/she lost balance and fell. Resident to hospital by ambulance. 6:42 p.m. on 12/16/16 resident returned to facility. Diagnoses of closed displaced fracture of greater tuberosity of right humerus; contusion of head; and traumatic hematoma of right knee. Resident will require staff assistance in meeting all activities of daily living. The HCSP lacked revision to include interventions to meet the resident ' s need for	S3155		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3155	Continued From page 11	S3155		

assistance with activities of daily living and resident ' s risk for falls.

3:22 p.m. on 1/23/16 resident walking with walker to dining room around 11:30 a.m. Resident began to fall backwards and an employee able to slow resident's fall.

The HSCP lacked revision to address the resident ' s ongoing risk for falls.

10:00 p.m. on 3/23/16 resident used pendant at 8:25 p.m. Resident found on floor at end of bed. Resident stated he/she slid off the end of the bed. Encouraged resident to use pendant as needed.

The record contained an annual functional capacity screen dated 6/30/16 that indicated the resident was independent with walking, transferring, and toileting; experienced impaired short-term memory, memory recall, and decision making; and utilized a walker. The functional capacity screen did not indicate the resident was at risk for falls.

The HCSP dated 6/30/16 lacked interventions to address resident ' s risk for falls.

Progress note at 6:17 p.m. on 9/16/16 resident found by another resident on floor of bathroom. Resident stated he/she passed out and he/she could not move left leg. To hospital by ambulance.

Documentation on 9/17/16 recorded resident had surgery for repair of fractured hip.

During an interview at 12:35 p.m. on 11/17/16 certified medication aide F stated he/she instructed resident to call for assistance when

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S3155	Continued From page 12 getting up, especially when transferring at night and to wear proper footwear. At 4:22 p.m. on 11/17/16, when asked what interventions were implemented after resident fractured arm, director of nursing B stated physical and occupational therapy initiated and he/she instructed staff to check environment of resident ' s apartment to ensure walkways were clear. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to address the resident ' s risk for falls identified on the functional capacity screen. Resident #526 experienced 6 falls with 2 falls resulting in fractures. - Record review for resident #520 revealed an admission date of 9/30/16 and diagnoses of chronic atrial fibrillation and benign neoplasm of meninges. The admission functional capacity screen dated 9/30/16 indicated the resident required supervision with toileting and transferring; physical assistance with walking; experienced impaired short-term memory, decision making, and memory recall; utilized a walker or wheelchair for mobility; and was at risk for falls. The health care service plan dated 9/30/16 documented one-person assistance with gait belt to ambulate with resident or mobilize resident in wheelchair; supervise transfers for resident safety; and reminders and cueing due to resident's impaired cognition. In the health care service plan section for "current or recent problems and risks falls, unsteadiness" director of nursing B documented interventions of personal	S3155		

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S3155	Continued From page 13	S3155		

call pendant and encourage supervision with ambulation.

Review of the progress notes revealed the following documentation by licensed nurses:

10:40 p.m. on 9/30/16 resident used call pendant at 9:30 p.m. to notify staff of fall. Resident on floor in doorway to bedroom. Resident stated reached for light switch and fell. Small V-shaped skin tear to top of left hand.

11:41 p.m. on 10/5/16 resident used call pendant around 11:20 p.m. Found resident kneeling next to bed needing assistance to get to bathroom.

1:04 p.m. on 10/7/16 resident called at 5:55 a.m. and found on bathroom floor. Resident stated he/she fell when turning to flush toilet.

2:35 p.m. on 10/7/16 licensed nurse went to resident's room and found resident on knees on floor between beds. Resident stated he/she leaned out of bed to pick something up and "I just fell and busted my face." Minimal bleeding from nose.

4:54 p.m. on 10/9/16 resident used call pendant at 4:30 p.m. Resident sitting on floor between beds.

9:24 p.m. on 10/30/16 resident used call pendant. Resident found on floor next to bed. Resident stated he/she did not fall but could not explain how he/she got to the floor.

10:52 p.m. on 10/30/16 resident used call pendant and resident found again on floor next to bed. Resident again stated he/she did not fall. Resident denied head contact but there was an

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	N087082	A. BUILDING: _____ B. WING _____	11/23/2016

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(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
S3155	Continued From page 14 abrasion to right forehead. Encouraged resident to use pendant when needing to ambulate. 11:36 p.m. on 10/31/16 resident had injury fall at 6:25 p.m. in bathroom. Resident found on back on bathroom floor with walker on top of resident. Resident stated he/she lost balance and fell. Resident received 2 skin tears to left elbow. 7:15 p.m. on 11/8/16 resident called for assistance. Resident found lying on back in front of toilet. Resident stated he/she lost balance and sat down. 5:25 p.m. on 11/15/16 resident called for assistance. Resident found lying on bathroom floor with head resting on wall. Resident stated was turning around in bathroom, lost balance, and fell. Red area to back of head. 5:02 p.m. on 11/16/16 resident was working with physical therapy in hallway and fell. Resident bent over to move catheter bag and fell backward. Physical therapist stated he/she used gait belt to lower resident to floor. At 12:10 p.m. on 11/17/16 certified medication aide (CMA) F stated resident was very unsteady and he/she tried to walk with resident but resident would not call for assistance with toileting or transferring. CMA F stated he/she tried to make sure resident had walker within reach and wore proper footwear. During an interview at 4:50 p.m. on 11/17/16 director of nursing B stated resident falls were discussed in quality review meetings with an added intervention of referral to physical and occupational therapy.	S3155		

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	N087082	A. BUILDING: _____ B. WING _____	11/23/2016

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S3155	Continued From page 15 The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to address resident #520 ' s risk for falls identified on the functional capacity screen. - Record review for resident #524 revealed an admission date of 2/3/15 and diagnoses of dementia and atrial fibrillation. The record contained a functional capacity screen 1/28/16 that indicated the resident was independent with toileting and transferring; required supervision with walking; experienced impaired short-term memory, decision making, and memory recall; utilized a walker for mobility; and was at risk for falls. The health care service plan dated 1/28/16 documented services of supervision with mobility due to unsteady gait. The health care service plan lacked interventions to address the resident's risk for falls. Progress notes contained the following entries by licensed nurses: 6:54 a.m. on 9/29/15 resident found on floor near bed. Resident stated he/she was making bed and got tangled in comforter. 1:41 p.m. on 10/8/15 resident found on floor this a.m. Resident lying on floor with head near foot of bed. Resident stated he/she rolled out of bed. 5:00 p.m. on 1/24/16 staff found resident face down on floor in living room. Resident stated he/she stood up and fell over. Bruise next to right eye and bruise on right forearm.	S3155		

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S3155	Continued From page 16 9:39 p.m. on 7/29/16 family member reported resident fell when getting up from chair. 7:06 a.m. on 8/20/16 resident had unwitnessed fall at 5:15 a.m. At midnight resident was up and dressed for the day. Licensed nurse reoriented resident and he/she went back to bed. "Due to resident's condition it is unknown exactly what happened during fall." Bruise noted to right knee. At 12:30 p.m. on 11/17/16, certified medication F stated, as a fall intervention, he/she checked on resident to remind of meals and at medication passes. During an interview at 4:30 p.m. on 11/17/16 when asked for interventions put into place to address risk for falls, director of nursing B stated falls discussed in quality review meetings and obtain a referral to physical and occupational therapy. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to address resident #524's risk for falls identified on the functional capacity screen.	S3155		
S3212 SS=E	26-41-205 (g) (1) Medication Ordering (g) Ordering, labeling, and identifying. All medications and biologicals administered by licensed nurses or medication aides shall be ordered from a pharmacy pursuant to a medical care provider ' s written order. (1) Any resident who self-administers and manages personal medications may request that a licensed nurse or medication aide reorder the resident ' s medication from a pharmacy of the	S3212		

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S3212	Continued From page 17 resident ' s choice. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed records reviewed. Based on interview, observations, and record review for all residents receiving facility management of medications, the administrator failed to ensure all medications and biologicals administered by licensed nurses or medication aides were ordered from a pharmacy pursuant to a medical care provider's written order. Findings included: - During tour of the medication room at 10:45 a.m. on 11/16/16 with certified medication aide (CMA) D observed a plastic box with a plastic pull tab in the medication refrigerator. CMA D stated the plastic box held emergency stock medications and if a resident needed one of the medications staff would break plastic tab off the box, remove the medication, attach a red plastic tab to the box, and send fax to pharmacy to notify a resident was given the medication. Observed a list on the box to indicate contents that included 1 Humalog insulin pen, 1 Lantus insulin pen, 1 Levemir insulin pen, 1 Novolog insulin pen, 3 Phenergan (to treat nausea) 25 milligrams (mg) suppositories, and controlled medication Ativan (anti-anxiety medication) 2 mg per milliliter injection 2 vials. CMA D removed a large nylon bag from a lower cabinet and stated this bag also	S3212		

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S3212	Continued From page 18 held emergency medications. Review of the contents listed on the bag revealed stored inside the bag were injectable/intravenous medications, inhalation medications, eye/ear medications, antibiotics, anticoagulants, antihypertensives, anti-psychotics, and controlled medications that did not require refrigeration. CMA D stated if a resident needed one of these medications due to a new order or medication not available in the resident's supply and it was after pharmacy hours, the person administering medications would remove the medication and administer the medication to the resident. During an interview at 11:40 a.m. on 11/17/16, director of nursing stated purpose of emergency medication kit was to ensure access to medications when pharmacy unable to deliver medications to facility. The administrator failed to ensure all medications and biologicals administered by licensed nurses or medication aides were ordered from a pharmacy pursuant to a medical care provider's written order.	S3212		
S3214 SS=D	26-41-205 (g) (4) Sample & Indigent Medication Program Meds (g) (4) Licensed nurses and medication aides may administer sample medications and medications from indigent medication programs if the administrator or operator ensures the development of policies and implementation of procedures for receiving and identifying sample medications and medications from indigent medication programs that include all of the following conditions: (A) The medication is not a controlled medication.	S3214		

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S3214	Continued From page 19 (B) A medical care provider ' s written order accompanies the medication, stating the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration. (C) A licensed nurse or medication aide receives the medication in its original, unbroken manufacturer ' s package. (D) A licensed nurse documents receipt of the medication by entering the resident ' s name and the medication name, strength, and quantity into a log. (E) A licensed nurse places identification information on the medication or package containing the medication that includes the medical care provider ' s name; the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider ' s order. Facility staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches the information on the medical care provider ' s order. (F) A licensed nurse informs the resident or the resident ' s legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies. The resident ' s clinical record shall contain documentation that the resident or the resident ' s legal representative has received the information and accepted the risk of potential adverse consequences.	S3214		

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S3214	Continued From page 20 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(4) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed records reviewed. Based on interview, observation, and record review for 1 (#524) of 6 residents sampled, licensed nurses failed to implement the policy and procedure for receiving and identifying a sample medication that included a medical care provider's written order accompanied the medication, stating the resident's name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration; a licensed nurse documented receipt of the medication by entering the resident's name and the medication name, strength, and quantity into a log; a licensed nurse placed identification information on the medication bottle that included the medical care provider's name; the resident's name; the medication name, strength, dosage, route, and frequency of administration, and any cautionary instructions as documented on the medical care provider's order; two licensed nurses or a licensed nurse and a medication aide verified that the information on the medication matched the information on the medical care provider's order; a licensed nurse informed the resident or the resident's legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies; and the resident's clinical record contained documentation that the resident	S3214		

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S3214	Continued From page 21 or the resident's legal representative had received the information and accepted the risk of potential adverse consequences. Findings included: - During tour of the medication room at 10:45 a.m. on 11/16/16 when asked if any residents received sample medications, certified medication aide (CMA) D opened a medication cart and removed a bottle of Xarelto (to treat and prevent blood clots) tablets. The bottle contained the handwritten name of resident #524. CMA D stated the resident's family member would bring the medication to the facility from the medical care provider's office and staff would write the resident's name on the bottle. Record review for resident #524 revealed an admission date of 2/3/15 and a diagnosis of atrial fibrillation. The functional capacity screen dated 1/28/16 indicated resident required physical assistance for medication management. The health care service plan dated 1/28/16 documented the service of facility staff to administer and reorder medications. The record contained a medical care provider's order 9/9/16 for family member to come to office to pick up samples of Xarelto and an order dated 9/14/16 for Xarelto 15 milligrams 1 tablet by mouth daily. At 12:45 p.m. on 11/16/16, director of nursing B provided the facility policy and procedure "Accepting Delivery of Sample Medications." Licensed nurse B confirmed the policy and procedure was not followed. For resident #524, licensed nurses failed to implement the policy and procedure for receiving	S3214		

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S3214	Continued From page 22 and identifying a sample medication that	S3214		
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 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.	S3215		

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S3215	Continued From page 23 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)(1) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed records reviewed. Based on interview, observation, and record review for all residents receiving medication management the administrator failed to ensure licensed nurses and certified medication aides stored all controlled medication in separately locked compartments within a locked medication room and failed to ensure only licensed nurse and certified medication aides authorized to prepare and administer medications during a particular scheduled shift had access to the medication room. Findings included: - At 10:45 a.m. on 11/16/16 when asked for the person administering medications, certified medication aide (CMA) D stated he/she was working the floor but had keys to the medication room. CMA D unlocked the medication room. Observed 2 medication carts in the room with a key in the lock of each medication cart. Observed a locked black box in unlocked refrigerator. CMA D unlocked the box that held lorazepam 1 milligram per milliliter labeled for resident #522. Also observed a plastic box with a plastic pull tab. CMA D stated the plastic box held emergency stock medications and if a resident needed one of the medications staff would break plastic tab off the box and send fax to pharmacy to notify a resident was given the medication. Observed a list on the box to indicate contents included controlled medication Ativan (anti-anxiety medication) 2 milligrams (mg) per	S3215		

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S3215	Continued From page 24 milliliter injection 2 vials. CMA D removed a large nylon bag from a lower cabinet and stated this held emergency medications. Review of the contents listed on the bag revealed controlled medications Ambien (sleep aid) 5 mg 5 tablets, Ativan 0.5 mg 10 tablets, Klonopin (to treat panic disorder or anxiety) 0.5 mg, Lomotil (to treat diarrhea) 10 tablets, Tylenol #3 (to treat moderate to severe pain), Ultram (to treat moderate to severe pain), and Xanax (anti-anxiety) 0.25 mg 10 tablets. At 10:55 a.m. on 11/16/16, licensed nurse E came into the medication room and stated the controlled medications in the emergency medication bag were in a separate container with a green plastic tab. Licensed nurse E confirmed the medication room was locked but there was not a separate lock for these controlled medications. At 11:00 a.m. on 11/16/16, director of nursing B confirmed the emergency kit controlled drugs were not stored in a locked medication cart, cabinet, or refrigerator inside the locked medication room and that certified medication aides not administering medications had access to medications. At 1:15 p.m. on 11/16/16, director of nursing B provided the facility's "Storage of Medications" policy that documented "Only persons authorized to prepare and administer medications during particular scheduled shift shall have access to the medication room, including any keys." The administrator failed to ensure licensed nurses and certified medication aides stored all controlled medication in separately locked compartments within a locked medication room	S3215		

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S3215	Continued From page 25 and failed to ensure only licensed nurse and certified medication aides authorized to prepare and administer medications during a particular scheduled shift had access to the medication room.	S3215		
S3265 SS=E	26-41-104 (a) Disaster and Emergency Preparedness (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(a) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed records reviewed. Based on interview and record review for 1 (#521) of 6 residents sampled and 2 (#528 and #529) non-sampled residents requiring two-person transfer assistance, the administrator failed to ensure a sufficient number of staff members on the 10:00 p.m. to 6:00 a.m. shift to take residents who required assistance in an emergency or disaster to a secure location. Findings included: - At 10:40 a.m. on 11/14/16, director of nursing B stated a staffing pattern of one licensed nurse and one certified staff member for the 10:00 p.m. to 6:00 a.m. shift. Administrator C confirmed only	S3265		

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S3265	Continued From page 26 two employees present on the 10:00 p.m. to 6:00 a.m. shift. During an interview at 11:00 a.m. on 11/14/16, administrator C stated the last emergency drill with evacuation of resident to a safe place was on 4/8/16. Administrator C provided documentation of the drill with signatures of 21 employees participating in the drill with evacuation of residents to 3 separate areas. Administrator C confirmed he/she had not conducted a drill with 2 people participating in order to determine if 2 employees could safely evacuate residents to a safe place. Review of the resident roster revealed residents #521, #528, and #529 each required two-person transfer assistance. Review of the facility's evacuation plan revealed the person in charge at the time of the situation would call the director of nursing to come to the building. The plan documented "Residents will be escorted to three (3) shelter-in-place locations being the west location of the community and the northeast and southeast doors of the community. Each location will have at least one personnel posted, and begin a resident count." The plan documented a nursing employee would move all medication/treatment carts to one of the shelter-in-place locations and collect at least one laptop computer and emergency binders. The evacuation plan did not account for limited number of employees in the building on the 10:00 p.m. to 6:00 a.m. shift and the mobility needs of residents. The administrator failed to ensure a sufficient number of staff members on the 10:00 p.m. to 6:00 a.m. shift to take residents who required	S3265		

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S3265	Continued From page 27 assistance in an emergency or disaster to a secure location.	S3265		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed records reviewed. Based on record review and interview for residents not attending resident council meetings and all employees, the administrator failed to ensure disaster and emergency preparedness by ensuring a quarterly review of the facility's emergency management plan with employees and residents.	S3280		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOVE ESTATES SENIOR LIVING COMMUNITY	1400 S 183RD WEST GODDARD, KS 67052

(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
S3280	Continued From page 28 Findings included: - Review of resident council minutes on 11/14/16 revealed discussion of the facility's emergency management plan on 4/1/15, 9/2/15, 2/3/16, and 9/7/16. Noted that all residents did not attend resident council meetings. At 10:15 a.m. on 11/16/16, administrator C provided dates and documentation of employee review of the emergency management plan 2/12/16, 4/8/16, and 8/12/16. Administrator C stated there was no documentation of review of the pan with employees in 2015. Administrator C stated the plan was reviewed with only those residents attending resident council meetings. The administrator failed to ensure disaster and emergency preparedness by ensuring a quarterly review of the facility's emergency management plan with employees and residents.	S3280		