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 _____	07/06/2023

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
S 000	INITIAL COMMENTS The following citation represents the findings of an Abbreviated Survey with complaint investigations 178086, 178155, 178258, 179167, 181214 for the above named Assisted Living facility conducted on 07/05/23 and 07/06/23.	S 000		
S3200 SS=G	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) The facility reported a census of 59 residents (R). The sample included three residents and one closed record review. Based on interview, and record review the administrator failed to	S3200		

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

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S3200	Continued From page 1 ensure designated staff ordered and administered Sennosides-Docusate Sodium (stool softener/stimulant laxative) as ordered by the physician for 1 (R5) of 1 closed record review. This failure resulted in the resident not receiving 31 consecutive doses causing the resident to experience constipation which resulted in rectal impaction and the need for hospitalization and surgical bowel procedure. Findings included: - Review of R5's electronic medical record revealed she moved into the facility on 03/10/21 with diagnosis of hypertension and constipation. R5's "Functional Capacity Screen" dated 03/02/23 identified the resident needed physical assistance to manage her medications and was unable to manage her medical treatments. It also identified she had some difficulty with memory recall. R5's "Negotiated Service Agreement/Health Care Service Plan" dated 03/03/23 revealed the facility nursing staff provided physical assistance with medication administration and medications were provided by a local pharmacy. Review of R5's signed physician orders dated 04/26/23 included the following medication orders: Polyethylene glycol 3350 powder (Miralax -laxative); 17 gram/dose, 1 cap full, use in water or beverage of choice, daily Stool softener-Stimulant laxative (sennosides-docusate sodium) - 8.6-50	S3200		

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S3200	Continued From page 2	S3200		

milligram (mg) daily
Hydrocodone-Acetaminophen (narcotic pain medication) 10/325 mg, give ½ tablet four times a day while awake
Milk of Magnesia (MOM) for constipation, 30 milliliters if no bowel movement in three days per resident report - If no result from MOM in 12 hours give Bisacodyl 10mg suppository. If no results notify physician for further orders.

Review of R5's "Medication Administration Record" (MAR) revealed the following:

April 2023 - The staff administered the Miralax 15 out of 30 days and the resident refused it the other 15 days. The staff administered the Sennosides-Docusate Sodium 29 out of 30 days.

May 2023 - The staff administered the Miralax 24 out of 31 days and the resident refused it seven days. The staff administered the Sennosides-Docusate Sodium the first four days of the month and then marked it as "unavailable" the rest of the month.

June 2023 - The staff administered the Miralax daily prior to hospitalization and marked the Sennosides-Docusate Sodium as "unavailable". The resident also received a one-time dose of MOM, with no follow up of the medication's effectiveness.

Review of the resident's progress notes revealed the following:
05/31/23 - Medication Regimen Review completed. Noted the resident had Miralax and Senna S (Sennosides-Docusate Sodium) for

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S3200	Continued From page 3	S3200		

possible narcotic induced constipation.
06/02/23 at 03:44 PM - R5 complained of being bloated, bowel sounds active in all 4 quadrants and resident reported passing gas. "As Needed" MOM administered.
The record lacked follow up for effectiveness. Record also lacked notification of physician for resident's abdominal distention.

06/04/23 at 04:48 AM, R5's abdomen more distended at this time compared to Friday (06/02/23), R5 said she was uncomfortable with the distention. Physician notified and received an order for STAT (urgent / rush) KUB (a type of abdominal x-ray).
06/04/23 at 05:09 AM the resident had a large, soft, formed BM at 01:00 AM but had to strain during the process.
06/04/23 at 12:22 PM X-ray results indicated a rectal impaction and subsequent colonic obstruction. Physician informed and resident sent to local hospital for further evaluation.
06/05/23 at 01:29 PM per hospital staff, resident will have surgery on 06/07/23. On 07/05/23 at 12:55 PM Certified Medication Aide (CMA) E reported if a medication is not available for administration, we call the pharmacy to order it and let the nurse know it is not here.

On 07/05/23 at 12:59 PM Licensed Nurse (LN) D reported if a medication is not available the CMA is to call the pharmacy and notify nurse on duty and the Director of Nursing if needed. They need to look for it and investigate why it is not here and reorder it "STAT". LN D did not recall being told the resident did not have her Senna S available. He also stated if a resident is given MOM for constipation the expectation would be

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S3200	Continued From page 4	S3200		

they need to have a bowel movement within a certain time frame and if not, the nurse needs to call the physician for additional instructions.

On 07/05/23 at 02:43 PM Certified Nurse Aide G reported staff took the resident to the bathroom and helped with pulling her pants up and down, but the resident could do her own personal care related to toileting. Staff G also reported the resident was alert and oriented and could tell the aides if she did not feel well or had any concerns.

On 07/05/23 at 02:56 Certified Medication Aide H reported if a medication is not in the cart to give, staff need to look in the overstock for it, look to see if it had been ordered, and if not, the CMA notifies the nurse and calls the pharmacy to see if it had been delivered or what the problem was. CMA H acknowledged the pharmacy would have filled R5's Senna S and did remember that it was not available. CMA H stated the CMA's had notified the nurse and we were just waiting for the pharmacy to deliver it. When asked if they just waited for a whole month CMA H nodded her head in acknowledgement and did not know if anyone had called the pharmacy or physician to let them know.

On 07/06/23 at 07:33 AM Administrative Licensed Nurse C reported the CMAs should be calling the pharmacy or asking the nurse to call them. She stated the pharmacy said they filled it on 04/30/23 and it was delivered but do not know what happened as far as why it wasn't put in the cart or if it was delivered.

On 07/06/23 at 08:04 AM Pharmacist J reported

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S3200	Continued From page 5 they received a refill request for the SennaS on 04/29/23, it was filled on 04/30/23, and delivered to the facility on 05/01/23. He also reported there was no additional communication from the facility regarding this medication and needing it refilled or delivered. Review of the "Administering Medications" Policy dated 12/2012 revealed the medications must be administered in accordance with the medical provider's orders. Review of the "Adverse Consequences and Medication Errors" policy dated 02/2014 included the following: A "Medication Error" is when a medication is not prepared or administered in accordance with physician's orders. This may include Omission - when a drug is ordered but not administered. For R5, the administrator failed to ensure designated staff ordered and administered the resident's SennaS according to the medical providers written orders. This placed the resident in harm when she began experiencing bloating and difficulty having a bowel movement, resulting in the resident needing an abdominal x-ray which revealed the resident had a rectal impaction and subsequent colonic obstruction which required the resident to be admitted to the hospital and having bowel surgery. For R5, the administrator failed to ensure designated staff ordered and administered the resident's SennaS according to the medical provider's written orders. This resulted in harm to the resident when she experienced bloating	S3200		

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S3200	Continued From page 6 and bowel issues resulting in a rectal impaction/ colonic obstruction and subsequent hospitalization and bowel surgery to remove the impaction.	S3200		