STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N070008	A. BUILDING: _____ B. WING _____	04/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE RETIREMENT COMMUNITY ASSISTED L	702 W 7TH PO BOX 308 OVERBROOK, KS 66524

(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 represent the findings of a resurvey at the above named assisted living conducted on 04/11/2022.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or 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. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a)(1)(2) The facility reported a census of 19 residents (R). The sample included three residents and 2 focused record reviews. Based on interview, and record review the administrator failed to ensure the development of the "Negotiated Service Agreement/Health Service Plan (NSA/HCSP)" for one (R413) of three sampled residents and one (R415) of two focused reviews that included a	S3085		

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

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S3085	Continued From page 1 description of services provided and who provided that service related to insulin administration and blood sugar monitoring. Findings included: - R413's medical record revealed he moved into the facility on 10/01/11 with diagnosis of diabetes mellitus type 2. R413's "Functional Capacity Screen" dated 11/11/21 revealed he required physical assistance with medications and medical treatments. R413's "Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP)" dated 11/11/21 identified staff provided "Monthly wellness checks, insulin injections, blood sugar checks..." The NSA/HCSP failed to identify the Certified Medication Aide (CMA) checked resident's blood sugar and prepared the residents insulin pen and dialed it to the ordered dosage and the resident self injected the insulin. - R415's medical record revealed he moved into the facility on 09/11/17 with diagnoses of diabetes mellitus type two. R415's "Functional Capacity Screen" dated 11/11/21 revealed he required physical assistance with management of medications and medical treatments. R415's "Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP)" dated 11/11/21 identified nursing services for "insulin blood sugar checks and monthly wellness checks." The NSA/HCSP failed to identify the Certified Medication Aide (CMA) checked resident's blood sugar and prepared the residents insulin pen and	S3085		

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S3085	Continued From page 2 dialed it to the ordered dosage and the resident self injected the insulin. Observation on 04/11/22 at 11:42 AM Certified Medication Aide (CMA) B got the resident's Humalog insulin pen out of the med cart, put the needle on, dialed to two and primed the needle, and then she dialed the pen to 50 units as ordered. CMA B went to the resident's room, checked his blood sugar, and then handed the resident his insulin pen after she wiped an area on his abdomen with alcohol. The resident proceeded to self-inject his insulin accurately and safely. On 04/11/22 at 10:53 AM CMA B reported for residents who received insulin the CMA prepared the pen, dialed it to the appropriate dose, and handed it to the resident to self-inject. On 04/11/22 at 02:40 PM Administrative staff A acknowledged for R413 and R415 the NSA/HCSP did not identify the CMA would be checking the resident's blood sugar or dialing residents insulin pen and he self injected the insulin. The administrator failed to ensure designated staff developed NSA/HCSP for R413 and R415 that identified the service of CMA's dialing the residents insulin pen and the resident self-injecting the insulin.	S3085		
S3175 SS=E	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a	S3175		

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S3175	Continued From page 3 medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a) (1) The facility reported a census of 19 residents (R). The sample included 3 residents and 2 focused record reviews. Based on record review and interview for all residents who self-injected insulin, and for one (R413) sampled resident, the administrator failed to ensure a licensed nurse completed a self-administration medication assessment to ensure the each resident could safely, and accurately self-inject their insulin. Findings included: - Review of the resident roster provided by Administrative staff A on 04/11/22 identified 3 residents received insulin injections in the facility. On 04/11/22 at 10:53 AM Certified Medication Aide (CMA) B reported for residents who received insulin the CMA prepared the pen, diale it to the	S3175		

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S3175	Continued From page 4 appropriate dose, and handed it to the resident to self-inject. - R413's medical record revealed the resident moved into the facility on 10/01/11 with diagnosis of diabetes mellitus type 2. R413's "Functional Capacity Screen" identified he required physical assistance with medications and medical treatments. R413's "Negotiated Service Agreement/Health Care Service Plan" identified staff provided nursing services for insulin injections. The resident's record lacked a self-medication administration assessment to identify the resident could safely self-inject his insulin after the medication aide dialed it to the correct dosage. On 04/11/22 at 02:51 PM Administrative staff A reported she watched residents self-inject their insulin to make sure they could do it accurately, but had not written any type of assessment on paper. The administrator failed to ensure designated staff completed a self-administration assessment to ensure residents could safely and accurately self-inject their insulin. This had the potential to affect all resident who self-injected their insulin.	S3175		
S3305 SS=E	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure	S3305		

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S3305	Continued From page 5 the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-207 (b)(4) The facility reported a census of 19 residents. Based on observations and interview the administrator failed to ensure staff implemented procedures to prevent the spread of infections by the failure to ensure staff did not touch ready to	S3305		

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S3305	Continued From page 6	S3305		

eat food with potentially contaminated gloves. This had the potential to effect the residents who received bread served with their meal.

Findings included:

- Observation on 04/11/22 at 12:07 PM observed Dietary Staff (DS) C prepared to serve lunch. DS C put on gloves, pulled back the foil on the steam table pans, and retrieved serving utensils out of the drawer for serving. With the same gloves on, DS C opened the cabinet, retrieved a loaf of bread, reached in, took out a few slices of bread, retrieved a knife out of the drawer, and then cut the bread in half. DS C retrieved a serving pan out of the cabinet, tore off a piece of foil, and then put the bread in the pan. With the same gloves on DS C retrieved a peanut butter and jelly sandwich from the refrigerator, retrieved a bag of cheese curls out of the cabinet, then reached in with the same gloves on and put some cheese curls on the plate. DS C then proceeded to fix plates wearing the same gloves and put the bread on plates of those who wanted it. During the serving of the meal DS C further touched multiple drawers, her shirt, and other items that were not considered clean.

On 04/11/22 at 12:22 PM DS C acknowledged she should have changed her gloves or used something different to handle the bread.

The administrator failed to ensure dietary staff served foods using techniques to ensure the prevention of the spread of infections by the failure of staff to use proper glove usage when handling ready to eat foods.