STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N084007	A. BUILDING: _____ B. WING _____	C 03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF RUSSELL	1070 E WICHITA AVENUE RUSSELL, KS 67665

(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 the licensure resurvey with attached complaints (#169832, #169238, #169239, #167088) for the above named assisted living facility conducted on 03/02/22, 03/03/22, 03/07/22 and 03/08/22.	S 000		
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 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)(C) The census totaled 28 residents. Based on observations, interview, and record review, the facility failed to ensure a licensed nurse or medication aide remained with residents, including Resident (R) 903 until their/her	S3201		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/08/22

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S3201	Continued From page 1	S3201		

medications were ingested.

Findings included:

- Review of the Resident (R) roster provided by Licensed Nurse (LN) B revealed 28 of 28 residents had some of all medications administered by facility staff, which included licensed nurses and/or certified medication aides.

Review of R903's medical record revealed she moved into the facility on 01/24/22 with diagnoses of anxiety disorder and major depressive disorder.

Review of the resident's "Functional Capacity Screen" dated 01/26/22 revealed the resident required physical assistance with management medications

Review of the resident's "Negotiated Service Agreement/Health Care Services Plan" dated 01/31/22 revealed facility staff would order, prepare, reorder, give medications, and monitor for side effects.

The "Nurse's Note" dated 08/07/22 at 08:20 AM recorded, "Over the weekend, staff found multiple Tylenol tablets in resident's room. Staff has been instructed multiple times to watch resident take her medications. Resident has an order for Tylenol 1000 mg TID [three times per day] for pain. Resident doesn't refuse Tylenol but also doesn't take the tablets and keeps them in her room. The tablets found have been disposed of and this nurse sent a request to D/C [discontinue] Tylenol order and only keep PRN [as needed] order. Will update when orders are received."

Observations on 03/07/22 revealed the following:

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S3201	Continued From page 2 At 11:31 AM, Certified Medication Aide (CMA) C prepared medications for R903 at the medication cart, located at the door of the dining room. R903 sat in the dining room at this time. At 11:32 AM, CMA C took the prepared medications in to R903. The cup contained two Tylenol pills and one antibiotic pill. CMA C gave the resident the medication and walked away from the resident and back toward the medication cart. The surveyor asked CMA C about leaving the resident before medications were ingested and CMA C returned to R903 at that time. R903 had difficulty swallowing the Tylenol medication. After putting one Tylenol in mouth she could not swallow the pill and had to spit the pill back out into her hand. R903 stated she could not swallow the pill and that it was too big. The facility's "Medication: Administration" policy obtained on 03/08/22 recorded, "See the current Senior Rx Care Pharmacy Policy and Procedure Manual for Nursing Care Facilities for medication administration guidelines if not addressed in this manual." The "Senior Rx Care Pharmacy Medication Administration- General Guidelines" policy obtained on 03/08/22 from Operator A recorded, "13. The resident is always observed after administration to ensure that the dose was completely ingested." The facility failed to ensure a licensed nurse or medication aide remained with residents until their medications were ingested.	S3201		
S3310 SS=D	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a	S3310		

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S3310	Continued From page 3 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 (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: K.A.R 26-41-207 (c) The census totaled 28 residents. The sample included 3 residents, 1 focused record review resident, and review of 4 newly hired employees. Based on record review and interview for 1 Resident (R) 781 and Licensed Nurse (LN) B, the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines. Findings included: - Review of R 781's record revealed he admitted to the facility on 09/10/21 and the record lacked evidence of TB testing upon admission. Review of LN B's employee record revealed they hired onto the facility on 10/25/21. LN B's record further lacked evidence of a 2nd step of TB testing upon hire.	S3310		

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S3310	Continued From page 4 Electronic interview on 03/08/22 with Operator A confirmed resident R 781 did not receive TB testing on admission and further confirmed LN B did not receive a 2nd step of TB testing upon hire. The facility's "Tuberculin testing and symptom review" policy obtained on 03/08/22 recorded, "Each new resident and employee shall receive a two-step tuberculin skin test or a blood assay for Mycobacterium tuberculosis (BAMT) within seven (7) days of residency or employment." The facility failed to ensure the facility remained in compliance with the State Agency's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, which had the potential to affect all residents.	S3310		