STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N014005	A. BUILDING: _____ B. WING _____	R 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF CLAY CENTER	722 LIBERTY STREET CLAY CENTER, KS 67432

(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 Revisit and Correction Order #19-119 visit at the above named Assisted Living Facility in Clay Center, Kansas on 8/13/19, 8/14/19, and 8/15/19.	{S 000}		
{S3200} SS=E	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 census equalled 17 the sample included three Residents. The Resident Roster identified 10 with facility managed medications and seen with self administered medications. Based on observation, interview, and review of record, for three of three sampled Residents with facility managed medications (#1099, #1088, and	{S3200}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N014005	A. BUILDING: _____ B. WING _____	R 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF CLAY CENTER	722 LIBERTY STREET CLAY CENTER, KS 67432

(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
{S3200}	Continued From page 1 #1115), the Administrator failed to ensure all medications and biological's administered to Residents in accordance with a medical care provider's written orders and in accordance with professional standards of practice. Findings included: - Review of record revealed #1099 admitted to facility with diagnoses of severe degenerative disc disease of spine, scoliosis, hypertension, irritable bowel syndrome, diverticulosis, and cognitive decline. Current functional capacity screen dated 6/18/19 assessed #1099 unable to perform medication and treatment management. Current negotiated service agreement/health service plan of 6/18/19 documented facility staff to administer medication. August 2019 MAR (medication administration record) documented facility administration of medications. Comparison of the August 2019 MAR with current written, signed physician's orders revealed discrepancies. MAR contained orders for: Namenda (dementia) 10mg (milligrams) PO (by mouth) BID (twice daily); the physician's written order directed 5mg daily Miralax (laxative powder) 17gm (grams) daily; the written physician's order lacked this medication Tylenol (analgesic) ES (extra strength) two tabs PO every 8 hours: the written physician's order directed Tylenol 500mg two tabs TID (three times daily)	{S3200}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N014005	A. BUILDING: _____ B. WING _____	R 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF CLAY CENTER	722 LIBERTY STREET CLAY CENTER, KS 67432

(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
{S3200}	Continued From page 2 Aspirin (cardiac prophylactic) 325mg daily; the written physician's order recorded this medication not daily but PRN (as needed) Areds Preservision (eye vitamin/supplement) one tab PO BID; the physician's written order lacked directions for the Areds Systane (eye moisturizing) one drop ou (both eyes) BID; the physician's written order lacked directions for the Systane Biofreeze (topical pain reliever) gel QID (four times daily)PRN; this medication not included in current written signed physician's order Debrox (ear cleaning solution) to Left ear x3 days then irrigate with warm water PRN; this medication not included in current written signed physician's orders Mucinex (expectorant) 600mg PO BID PRN; this medication not included in current written signed physician's orders Mineral oil one teaspoon PO daily PRN; the physician's written order lacked directions for the mineral oil - Review of record revealed #1088 admitted to facility 9/11/17 with diagnoses of hypertension, osteoporosis, gastroesophageal reflux disease, and history of anemia. Current functional capacity screen dated 9/11/18 assessed #1088 unable to perform medication and treatment management. Current negotiated service agreement/health service plan of 9/11/19 documented facility staff to administer medication. August 2019 MAR (medication administration record) documented facility administration of medications.	{S3200}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N014005	A. BUILDING: _____ B. WING _____	R 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF CLAY CENTER	722 LIBERTY STREET CLAY CENTER, KS 67432

(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
{S3200}	Continued From page 3 Comparison of the August 2019 MAR with current written, signed physician's orders revealed discrepancies. MAR contained orders for: Ibuprofen (anti inflammatory) 400mg (milligrams) - 800mg PO (by mouth) every eight hours PRN (as needed) Ultram (narcotic like pain medication) 50mg one tab PO every 6 hours PRN; the most recent written physician's order lacked this medication Metamucil (laxative powder) according to directions on bottle; this medication not included in current written signed physician's orders - Review of record revealed #1088 admitted to facility 9/11/17 with diagnoses of hypertension, osteoporosis, gastroesophageal reflux disease, and history of anemia. Current functional capacity screen dated 9/11/18 assessed #1088 unable to perform medication and treatment management. Current negotiated service agreement/health service plan of 9/11/19 documented facility staff to administer medication. August 2019 MAR (medication administration record) documented facility administration of medications. Comparison of the August 2019 MAR with current written, signed physician's orders revealed discrepancies. MAR contained orders for: Cetrizine (allergies) 10mg (milligrams) PO (by	{S3200}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N014005	A. BUILDING: _____ B. WING _____	R 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF CLAY CENTER	722 LIBERTY STREET CLAY CENTER, KS 67432

(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
{S3200}	Continued From page 4 mouth) at HS (bedtime); the most recent written physician's order lacked this medication Naproxen (anti-inflammatory) 250mg PO one tablet PRN (as needed) every 12 hours; this order not included in the most recent written physician's orders Tylenol (analgesic) ER (extended release) 650mg PO TID (three times daily); the written physician's order directed Tylenol 325mg two tabs orally every 4-6 hours PRN On 8/14/19 at 2:30pm, Facility Nurse #B and Administrator #A confirmed the written signed orders failed to match the current orders of the August 2019 MAR... stated new copies of MARs have been sent to physicians for requested review and clarification. The Administrator failed to ensure all medications and biological's administered to #1088, #1099, and #1115, in accordance with medical care provider's written orders and in accordance with professional standards of practice.	{S3200}		
{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	{S3211}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N014005	A. BUILDING: _____ B. WING _____	R 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF CLAY CENTER	722 LIBERTY STREET CLAY CENTER, KS 67432

(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
{S3211}	Continued From page 5 the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(3) The census equalled 17 the sample included three Residents. The Resident roster identified 10 Residents with facility managed medications. Based on observation and interview, for four non-sampled (#1066, #1055, #1044, and #1077) with over the counter medications, the Administrator 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 8/13/19 at 4:00pm, in review of the facility medication room with Certified Medication Aide #C, the following noted to lack the first and last name of each Resident: #1066 - Tube of Selan Cream (skin antiseptic/barrier) and Bottle of Miralax (laxative powder) lacked a first and last name #1077 - Two packages of "Triple Antibiotic with Pain Relief" cream and a bottle of Loratidine (allergy) tablets, lacked a first and last name #1055 - Bottle of Naproxen (anti-inflammatory) 220 milligrams lacked a first and last name #1044 - bottle of GerKot (senna laxative tablets) lacked a first and last name	{S3211}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N014005	A. BUILDING: _____ B. WING _____	R 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF CLAY CENTER	722 LIBERTY STREET CLAY CENTER, KS 67432

(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
{S3211}	Continued From page 6 On 8/13/19 at 4:15 and 4:20pm Certified Medication Aide #C confirmed these items lacked the first and last name... stated he/she thought whoever checks in the medication when it is brought into the facility writes the first and last on the package... confirmed it was not always the nurse or the pharmacist... The Administrator failed to ensure for #1066, #1077, #1055, and #1044, the licensed nurse or licensed pharmacist placed the first and last names of Residents on each accepted, original, unbroken manufacturer's package of OTC medication for Resident administration.	{S3211}		
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. (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	S3214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N014005	A. BUILDING: _____ B. WING _____	R 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF CLAY CENTER	722 LIBERTY STREET CLAY CENTER, KS 67432

(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
S3214	Continued From page 7 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. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(4) The census equalled 17 the sample included three Residents. The Resident Roster identified 10 with facility managed medications and seven with self administered medications. Based on observation, interview, and review of record, for one non-sampled Resident who received a	S3214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N014005	A. BUILDING: _____ B. WING _____	R 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF CLAY CENTER	722 LIBERTY STREET CLAY CENTER, KS 67432

(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
S3214	Continued From page 8 sample medication (#1066), the Administrator failed to ensure the development of policies and procedures for receiving and identifying sample medications. Findings included: - Observations on 8/13/19 at 4:00pm revealed sampled medication packages in the medication storage room of facility for #1066. The medications lacked required identification and directions. - Review of the Resident Roster revealed medications for #1066 managed by the facility staff. The medication cupboards in the medication room contained 4 packages of Linzess (for constipation and irritable bowel syndrome). The Linzess lacked a pharmacy label, lacked the Residents' name, the physician's name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration. Certified Medication Aide #C verified the Linzess a sampled medication #1066 received from the physician's office... stated not aware of any log to check the medication into facility... not aware of the requirements for directions, physician's name, and other specifics to be stored with the medication... stated I opened this bottle on Sunday (8/11/19) and administered one... confirmed the bottle of four capsules still contained three... confirmed the MAR (medication administration record) for August 2019 with initials of administration on both 8/11/19 and 8/12/19... not sure why only one capsule absent.	S3214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N014005	A. BUILDING: _____ B. WING _____	R 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF CLAY CENTER	722 LIBERTY STREET CLAY CENTER, KS 67432

(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
S3214	Continued From page 9 On 8/14/19 at 2:30pm, Facility Nurse #B confirmed the facility policy for sampled medications not implemented... provided a copy of the facility policy and procedure which included the required processes... stated he/she started this position on 8/08/19... confirmed the sampled medication lacked correct labeling and a log to check the medication in upon arrival, and the medical record lacked an informed consent from the Resident or legal Representative... stated we will immediately implement the entire policy and procedure for sampled medications... For #1066, the Administrator failed to ensure the development of policies and procedures for receiving and identifying sample medications as required.	S3214		