| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N040002 | A. BUILDING: _____ B. WING _____ | 06/27/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ASBURY PARK | 200 SW 14TH NEWTON, KS 67114 |

| (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 |
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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a resurvey at the above named assisted living facility conducted on 6/26,27/2019. | S 000 | | |
| S3211 SS=E | 26-41-205 (g) (3) OVER THE COUNTER DRUGS<br><br>(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 the medication container.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-205(g)(3)<br><br>The facility reported a census of 21 residents. Based on observations and interview the administrator failed to ensure all over-the-counter medications contained the full name of the resident on medication bottle.<br><br>Findings included:<br><br>- During initial tour on 6-26-19 at 10:20 AM tour of the medication room for assisted living unit revealed an open bottle of milk-of-magnesia dated 4-21-19. Certified staff A reported the | S3211 | | |

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

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| S3211 | Continued From page 1<br>medication was considered"stock" and could be used if a resident ran out of their own and needed some. Staff A stated could use for multiple residents. Observation of the medication room in the memory care unit with certified staff B revealed an open bottle of Tylenol 325 mg with an open dated of 7-10-18, and bottle of Tylenol 500 mg with an open date of 9-2-18 and a box of Loperamide with an open date of 12-5-18. Staff B reported the medication was "stock" and could be used for multiple residents who needed it.<br><br>The administrator failed to ensure designated staff had assisted living resident's full names on all over the counter medications. | S3211 | | |
| S3280 SS=F | 26-41-104 (d) Disaster and Emergency Preparedness<br><br>(d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following:<br>(1) Orientation of new employees at the time of employment to the facility ' s emergency management plan;<br>(2) education of each resident upon admission to the facility regarding emergency procedures;<br>(3) quarterly review of the facility ' s emergency management plan with employees and residents; and<br>(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. | S3280 | | |

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| S3280 | Continued From page 2<br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-104(d)(3)<br><br>The facility reported a census of 21. The sample included 3 residents and 1 focused record review. Based on record review and interview for all residents and all facility employees, the administrator failed to ensure disaster and emergency preparedness by the failure to perform quarterly review of the facility's emergency management plan with employees and residents.<br><br>Findings included:<br><br>- During an interview on 6-26-19 at 11:50 AM administrative staff C reported he/she had not conducted reviews of the emergency management plan since he/she had been in the position.<br><br>At 4:00 PM on 6-26-19 Staff C reported he/she did not see anything in resident council minutes to verify review of the emergency management plan with residents and did not find anything in employee inservices to show review of the emergency management plan quarterly.<br><br>For all residents and employees, the administrator failed to ensure emergency preparedness by ensuring quarterly review of the emergency management plan with all staff and residents. | S3280 | | |
| S3310 SS=E | 26-41-207 (b) (5-6) (c) Infection Control Policies<br><br>(b) (5) prohibiting any employee with a communicable disease or any infected skin | S3310 | | |

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| S3310 | Continued From page 3<br>lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious;<br>(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<br>(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<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R 26-207(c)<br><br>The facility reported a census of 21 residents. The sample included 3 residents and 1 focused record review. Based on interview and record review for 3 (#115, #121, #361) of 4 residents the administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.<br><br>Findings included:<br><br>- Review of resident # 115's medical record revealed he/she admitted to the facility on 1/15/19 with diagnoses of hypertension, glaucoma, and osteoarthritis.<br><br>Review of the medical record revealed the resident received an initial TB skin test on 2-15-19, 28 days after admission. | S3310 | | |

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| S3310 | Continued From page 4<br>- Review of resident #121's medical record revealed he/she admitted to the facility on 1-2-18 with diagnoses of diabetes, hypertension and chronic kidney disease.<br><br>Review of the medical record revealed the resident received his/her initial TB skin test on 2-20-18, 49 days after admission.<br><br>- Review of resident #361's medical record revealed he/she admitted to the facility on 3-6-18 with diagnoses of dementia, hypertension and diabetes.<br><br>Review of the medical record revealed the resident received his/her initial TB skin test on 4-25-18, 50 days after admission.<br><br>During an interview on 6-27-19 at 12:05 PM licensed nursing staff C reported a residents TB skin test should be done when the come into the building and then a second one give 7-21 days later.<br><br>The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. | S3310 | | |