| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N046047 | A. BUILDING: _____ B. WING _____ | 12/13/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE COLLEGE SQUARE | 11000 OAKMONT AVENUE OVERLAND PARK, KS 66210 |

| (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<br><br>The following citations are the result of a survey for re-licensure with attached complaints conducted on 12/11/18, 12/12/18 and 12/13/18 at the above assisted living facility in Overland Park, KS. | S 000 | | |
| S3248 SS=F | 26-41-102 (d) Staff Qualifications Employee Records<br><br>(d) The employee records and agency staff records shall contain the following documentation:<br>(1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training;<br>(2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto;<br>(3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and<br>(4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide.<br><br>This REQUIREMENT is not met as evidenced by: | S3248 | | |

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 |
|---|---|---|---|
| | N046047 | A. BUILDING: _____ B. WING _____ | 12/13/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE COLLEGE SQUARE | 11000 OAKMONT AVENUE OVERLAND PARK, KS 66210 |

| (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 |
|---|---|---|---|---|
| S3248 | Continued From page 1<br>KAR 26-41-102 (d)<br><br>The census equaled 56 the sample included 4 residents, 3 closed chart residents and one focus review resident. Based on interviews and reviews of facility records, for 4 of 4 certified staff (#D, E, F, G) the operator failed to ensure the employee record contained supporting documentation from the nurse aide registry and criminal background checks (KBI).<br><br>Findings included:<br><br>- Review of personnel records for certified staff #D: hire/start of work date 4/25/18, KBI check submitted on 4/26/18, 1 day after hire.<br><br>Certified staff #E: hire/start of work date 7/11/18, KBI check submitted on 7/27/18, 16 days after hire.<br><br>Certified staff #F, hire/start of work date 10/22/18, KBI check submitted on 10/24/18, 2 days after hire, registry check not completed until 12/11/18, 2 months after hire.<br><br>Certified staff #G, hire/start of work date 5/30/18, KBI check submitted on 6/8/18, 9 days after hire.<br><br>Interview on 12/12/18 at 8:30am with facility operator #A, confirmed staff start of work dates.<br><br>The operator failed to ensure the employee record contained supporting documentation for criminal background checks prior to employment. | S3248 | | |
| S3310 SS=F | 26-41-207 (b) (5-6) (c) Infection Control Policies | S3310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N046047 | A. BUILDING: _____ B. WING _____ | 12/13/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE COLLEGE SQUARE | 11000 OAKMONT AVENUE OVERLAND PARK, KS 66210 |

| (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 |
|---|---|---|---|---|
| S3310 | Continued From page 2<br>(b) (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;<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>3310 tb guidelines<br>KAR 26-41-207(c)<br><br>The facility reported a census of 56 residents. The sample included 4 residents, 3 closed chart reviews and one focus review resident. Based on record review, and interview, for all residents of the facility, the operator failed to ensure 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>- On 12/11/18 at 2:30pm, during personnel review facility records lacked documentation for | S3310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N046047 | A. BUILDING: _____ B. WING _____ | 12/13/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE COLLEGE SQUARE | 11000 OAKMONT AVENUE OVERLAND PARK, KS 66210 |

| (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 |
|---|---|---|---|---|
| S3310 | Continued From page 3<br>tuberculosis (TB) facility TB skin tests for the following recent staff hired:<br><br>Licensed nurse #C, hire/start of work date 12/14/18, symptom screen only completed 12/11/17, no prior TB test on record, no facility TB test on record.<br><br>Certified staff #D, hire/start of work date 4/25/18, symptom screen only completed 4/25/18, prior TB test on record 3/2/18 lacked results, no facility TB test on record.<br><br>Certified staff #E, hire/start of work date 7/11/18, symptom screen completed 7/12/18, prior 2 step TB test completed 12/8/17, no facility TB test on record.<br><br>Certified staff #F, hire/start of work date 10/22/18, symptom screen only completed 10/23/18, prior 2 step TB test completed 9/8/18, no facility TB test on record.<br><br>Certified staff #G, hire/start of work date 5/30/18, symptom screen completed on 5/31/18, prior 1 step TB test completed on 3/21/17.<br><br>Interview on 12/12/18 at 8:30am with facility operator #A confirmed facility TB tests were not completed per guidelines.<br><br>For all residents of the facility, the operator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. | S3310 | | |