STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N098002	A. BUILDING _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREGO LEMKE ASSISTED LIVING	303 N 14TH ST WA KEENEY, KS 67672

(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 an Assisted Living/Residential Healthcare Licensure Resurvey.	S 000		
S9999	KAR Final Observations The facility's assisted living had a census of 7 residents. Based on observation, interview and record review, the facility failed to provide nursing staff attendance at all times for the 7 residents, who reside in the assisted living facility. Findings included: - On 9/1/16 at 11:05 AM, observation revealed alarmed double doors with clear glass window pane separated the long term care facility from the assisted living dining room to the east. On 9/1/16 at 11:02 AM, Nurse B reported staffing for assisted living consisted of a certified medication aide scheduled for 7:00 AM to 7:00 PM, a licensed practical nurse part time, and long term care nurse coverage as needed. Nurse B stated the long term care nurse does rounds every 2 hours, from 7:00 PM to 7:00 AM and call lights are answered by long term care staff. On 9/1/16 at 2:10 PM Nurse A verified staff scheduled from 7:00 AM to 7:00 PM for assisted living, and from 7:00 PM to 7:00 AM the long term care nurse made rounds every 2 hours and covered the residents' needs and the long term care staff also answered the call lights. Nurse B verified alarmed double doors with clear glass window pane separated the long term care facility from the assisted living dining room to the	S9999		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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
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S9999	Continued From Page 1 east. The facility failed to provide continuous, qualified staff from 7:00 PM to 7:00 AM for the 7 residents who reside in the assisted living facility.	S9999		