Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011003	A. BUILDING: _____ B. WING _____	02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 for the above named facility conducted on 02/15/23 and 02/16/23.	S 000		
S3211 SS=D	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 the medication container. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205(g)(3) The facility reported a census of 15 residents. Based on observation and interview the administrator failed to ensure a licensed pharmacist or a "Licensed Nurse" (LN) placed the full name of the resident on over the counter (OTC) medications located in the assisted living medication cart. Findings included:	S3211		

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

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S3211	Continued From page 1 - Observation on 02/15/23 at 1109 AM of the assisted living medication cart located in the facility living room, CMA B opened the locked cart, and in the third drawer down were the following opened OTC bottles which lacked the resident's full name: Tylenol 500 milligram tablets Sunmark Vitamin C Vitamin B-12 1000 micrograms Banophen 25 milligram capsules Rugby Melatonin 5 milligram Flintstones Gummies Vitamin Complete Interview on 02/15/23 at 1113 AM with LN A and CMA B, they confirmed the OTC bottles lacked the full name of the residents the OTC was for. The administrator failed to ensure a licensed pharmacist, or a "Licensed Nurse" (LN) placed the full name of the resident on over the counter (OTC) medications located in the assisted living medication cart.	S3211		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: K.A.R.26-41-206 (d)(1)	S3299		

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S3299	Continued From page 2 The facility reported a census of 15 residents. The sample included three "Residents'" (R's) (R1, R2, and R3). Based on observation and interview the administrator failed to ensure the facility staff did not store or use food items beyond the item expiration date which were stored in the assisted living facility refrigerator in the dining room and the refrigerator in the assisted living serving / food storage area, and further failed to ensure the food items were stored according to manufacture recommendations. Findings included: - Observation on 02/15/23 at approximately 10:00 AM of the side-by-side refrigerator/freezer located in the resident dining room, revealed in the door of the refrigerator a five-pound container of Hiland sour cream with an expiration date of 10/26/22. In the freezer section were 17 individually packaged readymade meals with R3 name handwritten on each meal. Each meal had a sticker with the expiration date of 01/12/23. Observation on 02/15/23 at approximately 10:30 AM of the assisted living food serving and storage area revealed the following: on a metal serving cart sitting to the right side of the steam table was a large container of whipped margarine which stated to keep refrigerated. On the counter located on the south wall in front of the window sat a large, sealed container of mild chunky salsa which stated to store in a cool dry place and refrigerate after opening. Interview on 02/15/23 with licensed nurse A, he	S3299		

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S3299	Continued From page 3 confirmed all the items were beyond their expiration date. The administrator failed to ensure the facility staff did not store or use food items beyond the item expiration date which were stored in the assisted living facility refrigerator in the dining room and the refrigerator in the assisted living serving / food storage area, and further failed to ensure the food items were stored according to manufacture recommendations.	S3299		