STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057004	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(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 a Re-Licensure Survey with complaint investigation 165412 for the above named Assisted Living Facility conducted on 12/13/23 and 12/14/23.	S 000		
S3166 SS=D	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(e) The facility reported a census of 21 residents. Based on interview and record review the administrator failed to ensure two of two sampled Certified Medication Aides (CMA) were trained by a licensed nurse and delegated the nursing procedure for obtaining blood glucose checks according to the nurse practice act and amendments thereto. Findings included: - On 12/13/23 Administrator A provided newly hired employee files for review. On 12/13/23 at 04:00 PM surveyor requested delegation/competency checks for blood glucose	S3166		

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

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S3166	Continued From page 1 monitoring for Certified Medication Aide (CMA) C and CMA D. On 12/13/23 at 04:03 PM Administrative Licensed Nurse B reported there was one resident requiring blood glucose monitoring by staff by glucometer. She also stated she did not have any documentation regarding delegation/competency for the CMA's to check a resident's blood glucose. The operator failed to ensure the LN delegated the nursing task of monitoring a resident's blood glucose, which is not included in the CMA curriculum, for two of two newly hired CMAs who had monitored the resident's blood glucose.	S3166		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually.	S3175		

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S3175	Continued From page 2 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 21 residents (R). The sample included three residents and one focused record review. Based on interview and record review the administrator failed to ensure a licensed nurse completed an assessment for self-administration of insulin for one (R4) of one resident prior to the resident initially beginning to self administer his insulin. Findings included: -- On 12/13/23 at 03:09 PM Administrative Licensed Nurse B reported there was one resident in the facility who self-admiistered his own insulin. KAR 26-41-205(a)(1) The facility reported a census of 21 residents (R). The sample included three residents and one focused record review. Based on interview and record review the administrator failed to ensure a licensed nurse completed an assessment for self-administration of insulin for one (R4) of one resident prior to the resident initially beginning to self administer his insulin. Findings included: -- On 12/13/23 at 03:09 PM Administrative Licensed Nurse B reported there was one resident in the facility who self-administered his own insulin.	S3175		

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S3175	Continued From page 3 Review of R4's "Electronic Medical Record" (EMR) revealed he moved into the facility on 07/16/21 with diagnosis of type II diabetes. R4's "Functional Capacity Screen" dated 09/25/23 revealed the resident was independent with management of his medications. R4's "Negotiated Service Agreement" dated 09/27/23 revealed he was independent with medication administration. Review of R4's EMR include two "Nurse Assessment for Self-Administration of Medications" but both failed to include the assessment for the resident to be able to prepare/dial/and self-inject his insulin. On 12/14/23 at 10:53 AM Administrative Licensed Nurse B reviewed the self-administration of medication assessment for R4 and confirmed it did not include assessing the resident for self-administration of subcutaneous injections. The administrator failed to ensure a licensed nurse completed a self-administration assessment for R4 prior to his self-administering his insulin.	S3175		
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	S3211		

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S3211	Continued From page 4 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: KAR 26-41-205 (g)(3) The facility reported a census of 21 residents. Based on observation and interview, the administrator failed to ensure all over-the-counter medications were labeled with the resident's full name. This includes the need for the resident's full name to be on the original manufacturer's medication package and the medication container/tube. Findings included: - On 12/13/23 at 02:20 PM Certified Medication E unlocked the medication cart for inspection. The medication cart included the following over-the-counter medications with no name on them, initials only, or a first name only: a box of artificial tears had a resident's initials on the box and contained two eye drop bottles that did not include the resident's name; two bottles of generic pain medication, a bottle of aspirin, two bottles of Tums, bottle of docusate liquid, calcium + D, and a tube of triple antibiotic ointment.	S3211		

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S3211	Continued From page 5 Certified Medication Aide F reported when the family brings the medication in we usually just put the resident's initials on the bottle. On 12/13/23 at 04:37 PM Administrative Licensed Nurse B reported the aides came and told her the medications needed full names and not just initials. The administrator failed to ensure all over-the-counter medications included the full name of the resident they belonged to and included their name on the original manufacturer's medication package and the medication container.	S3211		