STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N030005	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK OF OTTAWA	1100 W 15TH STREET OTTAWA, KS 66067

(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 resurvey with a complaint #181384 at the above named Assisted Living conducted on 10/10/24 and 10/14/24.	S 000		
S 110 SS=F	26-39-103 (c) NOTICE OF RIGHTS AND SERVICES (c) Notice of rights and services. (1) Before admission, the administrator or operator shall ensure that each resident or the resident's legal representative is informed, both orally and in writing, of the following in a language the resident or the resident ' s legal representative understands: (A) The rights of the resident; (B) the rules governing resident conduct and responsibility; (C) the current rate for the level of care and services to be provided; and (D) if applicable, any additional fees that will be charged for optional services. (2) The administrator or operator shall ensure that each resident or the resident ' s legal representative is notified in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care. This STANDARD is not met as evidenced by: 0110 KAR 26-39-103(c)(1)(B) The facility reported a census of 34 residents. Based on interview and record review the operator failed to ensure resident (R)101, R102	S 110		

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

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S 110	Continued From page 1 and R103 were informed, both orally and in writing of the rules governing resident conduct and responsibility. Findings included: - R101 was admitted to the facility on 12/30/21 with diagnoses of dementia and type 2 diabetes mellitus. Review of R101's medical records failed to locate documentation that he was informed of the rules governing resident conduct and responsibility. On 10/10/24 at 12:45 PM Administrative Nurse A stated she did not provide R101 with rules of conduct or resident responsibilities upon admission to the facility. The operator failed to ensure R101 was informed both orally and in writing of the rules governing resident conduct and responsibility. - R102 was admitted to the facility on 11/20/23 with diagnoses of hypertension and tremors. Review of R102's medical records failed to locate documentation that she was informed of the rules governing resident conduct and responsibility. On 10/10/24 at 12:45 PM Administrative Nurse A stated she did not provide R102 with rules of conduct or resident responsibilities upon admission to the facility. The operator failed to ensure R102 was informed both orally and in writing of the rules governing resident conduct and responsibility.	S 110		

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S 110	Continued From page 2 - R103 was admitted to the facility on 01/13/22 with a diagnosis of hypertension. Review of R103's medical records failed to locate documentation that she was informed of the rules governing resident conduct and responsibility. On 10/10/24 at 12:45 PM Administrative Nurse A stated she did not provide R103 with rules of conduct or resident responsibilities upon admission to the facility. The operator failed to ensure R103 was informed both orally and in writing of the rules governing resident conduct and responsibility.	S 110		
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 3 This REQUIREMENT is not met as evidenced by: 3175 KAR 26-41-205(a)(1) The facility reported a census of 34 residents. The sample included three residents. Based on interview and record review the facility failed to ensure resident (R)101's medical records contained documentation of a completed medication self-administration assessment for insulin. Findings included: -R101's medical record revealed he moved into the facility on 12/30/21 with a diagnosis of type 2 diabetes mellitus. The 04/15/24 "Functional Capacity Screen" (FCS) documented R101 required physical assistance with medication administration. The 04/15/24 "Negotiated Service Agreement" (NSA) documented staff administered medications and assisted with insulin injections. R101 self-administered insulin after the insulin pen had been set by staff, if the nurse was not available to inject the insulin. Order dated 08/14/24 for Humalog Mix 75/25, inject 10 units, subcutaneous, in the evening for diabetes mellitus. Order dated 08/15/24 for Humalog Mix 75/25, inject 15 units, subcutaneous, in the morning for diabetes mellitus. Review of R101's medical records failed to locate	S3175		

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S3175	Continued From page 4 a medication self-administration assessment completed for self-injecting insulin. On 10/14/24 at 12:57 PM "Certified Medication Aide" (CMA) B stated R101 would at times self-inject his insulin if the nurse was not available to do this for him. On 10/14/24 at 01:55 PM Administrative Nurse A stated she could not locate a completed medication self-administration assessment for insulin in R101's medical records. The operator failed to ensure a medication self-administration assessment was completed for R101's self-injection of insulin.	S3175		