STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N031003	A. BUILDING: _____ B. WING _____	08/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW SENIOR LIFE	1417 W ASH ST JUNCTION CITY, KS 66441

(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 at the above named assisted living facility conducted on 8/22,26/2019.	S 000		
S3202 SS=E	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(4) The facility reported a census of 12 residents. The sample included 3 residents. Based on record review of 2 of 2 newly hired certified medication aide employee files and interview, the Operator failed to ensure the licensed nurse delegated the nursing procedure of dialing insulin dosage on an insulin pen and completing blood glucose/accucheck testing to each certified medication aide under the Kansas nurse practice act, K.S.A.65-1124 and amendments thereto. Findings included: - Review of resident #842's medical record revealed she admitted to the facility on 3-1-19 with a diagnosis of diabetes type 2. The resident had a physicians order for staff to monitor the resident blood sugars/accuchecks 1 time per week and administer Baseglar KwickPen solution 12 units at bedtime.	S3202		

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

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S3202	Continued From page 1 - Review of resident #852's medical record revealed he/she admitted to the facility on 11-1-17 with diagnosis of diabetes type 2. The resident had physicians orders for Lantus Solostar pen 50 units subcutaneous at bedtime and Novolog insulin pen 20 units three times a day. Observation on 8-22-19 at 12:53 PM revealed certified staff A prepared the resident's Novolog insulin pen. Staff put a new needle on the pen, dialed it to 20 and then took it to the resident in his/her room. The resident then wiped his abdomen with alcohol and injected the 20 units in his/her abdomen. Certified staff A failed to prime the pen with 2 units of insulin prior to dialing it to 20 units. During an interview on 8-22-19 at 11:07 AM certified staff A reported the certified medication aides would set up the resident's insulin and dial the pen to the correct dose and hand it to the resident to self-inject. Review of certified staff A and certified staff A's employee records lacked evidence of delegation related to the dialing of insulin pens and blood sugar checks / accuchecks. During an interview on 8-22-19 at 11:27 AM licensed nursing staff D reported he/she had not done competency testing for accuchecks or dialing of insulin pens for the certified staff. The operator failed to ensure designated staff ensured certified medication aides were properly trained on completion dialing dosage of insulin pens and completing blood sugar monitoring.	S3202		

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S3211	Continued From page 2	S3211		
S3211 SS=F	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: KAR 26-41-205(g)(3) The facility reported a census of 12 residents. Based on observations and interview the operator failed to ensure all over-the-counter medications contained the full name of the resident on medication bottle. Findings included: - During initial tour on 8-22-19 at 11:00 AM with certified staff A observation of the medication cart included a bottle of Calcium 500 mg, Acetaminophen 500 mg, and Aspirin 81 mg without the full name of the resident who used the medications. The Operator failed to ensure designated staff had resident's full names on all over the counter	S3211		

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S3211	Continued From page 3 medications.	S3211		
S3270 SS=E	26-41-104 (b) Written Emergency Plan (b) Each administrator or operator shall ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including the following: (1) Fire; (2) flood; (3) severe weather; (4) tornado; (5) explosion; (6) natural gas leak; (7) lack of electrical or water service; (8) missing residents; and (9) any other potential emergency situations. This REQUIREMENT is not met as evidenced by: KAR 26-41-104 (b)(6)(8) The facility reported a census of 12 residents. Based on record review and interview of the emergency management plan, the operator failed to ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters which included natural gas leak and missing residents. Findings included: - Review of the Disaster Plan for the facility revealed disaster plans for fire, flood (which included possible lose of water and electricity), severe weather, explosion, and tornado. The	S3270		

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S3270	Continued From page 4 disaster plan lacked preparedness for natural gas leak and missing resident. During an interview on 8-22-19 at 1:08 PM operator A confirmed the disaster plan did not include a plan for natural gas leak or missing resident. The operator failed to ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters which included natural gas leak and missing residents.	S3270		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by:	S3280		

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S3280	Continued From page 5 K.A.R 26-41-104(d)(3) The facility reported a census of 12 residents. Based on record review and interview the operator failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly reviews of the facility's emergency management plan with all assisted living employees. Findings included: - During survey conducted on 8-22-19 evidence of quarterly review of the emergency management plan with residents and staff was requested. Review of the quarterly emergency management plan reviews revealed the number of staff it was reviewed with ranged from 2 - 9 staff. During an interview on 8-22-19 at 1:30 PM operator staff B reported he/she did not review the plan with all the staff but just the staff that were present at the time of the drill. The administrator failed to ensure quarterly reviews of the facilities emergency management plan were conducted with all staff.	S3280		