STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050011	A. BUILDING: _____ B. WING _____	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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 03/12/25.	S 000		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (d) The facility reported a census of 18 residents. The sample included 3 "Residents'" (R)1, R2, and R3. Based on record review, interview, and observation, the Operator failed to ensure that each resident's functional capacity at the time of the screening was accurately reflected on that resident's screening from for R2 and R3. Findings included: - Record review for R2 revealed and admission date of 03/23/24 with diagnoses of chronic asthma, Diabetes Mellitus type two, macular degeneration, legally blind, and neuropathy. Review of R2's "Functional Capacity Screen" (FCS) dated 03/23/24 revealed R2 required supervision with bathing, dressing, transferring, walking/mobility, and she was unable to perform management of her medications and medical	S3082		

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

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S3082	Continued From page 1	S3082		

treatments. R1 was frequently incontinent and was marked with impaired memory/recall and impaired decision making. R2 was able to make herself understood and she understood others. R2 was marked at risk for falls, impaired vision, and impaired decision making. R2 used a walker mobility device.

Review of R2's combined "Negotiated Service Agreement/Health Service Plan" (NSA/HSP) dated 03/23/24 under the section titled "Medications and Treatments" and "Explanation of what resident administers themselves" was handwritten "nose spray and inhaler and able to utilize". It was marked that the "Self-administration of Medications Assessment" had been completed. Under the section titled "Skilled Nursing service to be provided", "Injections" was marked and handwritten was "Insulin" was four times a day. Under the section titled "Nursing Services to be supervised" the following were marked; Personal Care, Management of Medications, Management of Treatments and Management of behavioral symptoms.

Review of R2's medical record revealed a document titled "Medication Self-Administration Assessment" and was dated 08/22/24. The top of the document had eighteen questions on the left side and an area to assess if the resident was "unable, able with assist, or fully capable". The area to answer if the resident ability had handwritten over the area to answer, "See below". In the area for assessment results, it was handwritten "Only keep Flonase Nasal spray in room", it continued to be handwritten that R2 was able to demonstrate how to store and use the

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S3082	Continued From page 2	S3082		

Flonase nasal spray in front of the "Licensed Nurse" (LN).

Record review of R2's medical providers signed medication orders dated 02/05/25revealed R2 had orders for the following medications and OTC's;

Acetaminophen Arthritis 650 "milligram" (mg) tablets 2 tablets at hour of sleep for pain
Albuterol Sulfate HFA inhalation Aerosol solution 108 (90 base) 2 puffs every for hours as needed for shortness of breath (may keep at bedside)
Alendronate70 mg weekly
Basaglar Insulin 35 units subcutaneous every morning
Calcium carbonate 600 milligram 1 tablet by mouth every day
Cholecalciferol D3 2,000 international units (IU) by mouth every day
Diclofenac 50 mg 1 by mouth twice daily
Fiasp Insulin follow sliding scale
Flonase Nasal Spray 2 sprays each nostril daily
Gabapentin 600 mg 1 cap by mouth at hour of sleep
Headache Relief (250 milligram Tylenol, 250 milligram Aspirin, 65 mg caffeine) as needed for pain/headaches
Macrobid 100 mg 1 cap by mouth every day
Pravastatin 20 mg 1 by mouth at hour of sleep

Observation on 3/12/25 at approximately 02:35 PM in R2's bathroom medicine cabinet located on the east wall of the bathroom to the left of the sink were the following OTC medications:

1 bottle of hydrogen peroxide
1 bottle of lidocaine pain relieving cream

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S3082	Continued From page 3 1 bottle of Glucose tablets 1 bottle of Tums 1 bottle of Rexall ear relief drops 1 bottle of Equate Nasal spray Interview on 3/12/25 at approximately 02:35 PM with Operator/LN A confirmed the facility manages R2's medications and the only approved OTC medications to be in R2's room were the Flonase and Albuterol inhaler, she continued to confirm she "knew" about the "Tums" and was unaware of the other OTC medications present in the bathroom medicine cabinet. Operator/LN A confirmed R2's FCS was marked that R2 was unable to perform the management of her own medications/medical treatments. - Record review for R3 revealed an admission date of 04/14/24 with diagnoses of manic bipolar, depression, hypertension, coronary artery disease, systolic heart failure, self-care deficit, congestive heart failure, chronic obstructive pulmonary disease, and unilateral electroconvulsive therapy. Review of R3's FCS dated 04/14/24 revealed R3 required supervising with bathing and dressing. He was independent with toileting, transferring, walking/mobility and eating. R3 was marked as unable to perform his own medication/medical treatment management. R3 was continent, and had impaired short-term memory, impaired long-term memory, impaired memory/recall and impaired decision making. R3 was usually able to make himself understood and he understood others. R3 was identified at risk for falls and	S3082		

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S3082	Continued From page 4	S3082		

impaired decision making. R3 used no mobility device.

Review of R3's combined NSA/HSP dated 04/14/24 under the section titled "Medications and Treatments" had marked "Staff administration" of his medications and treatments. Under the section titled "Nursing Services to be supervised" the following were marked; Personal Care, Management of Medications, Management of Treatments and Management of behavioral symptoms.

Review of R2's medical record revealed a document titled "Medication Self-Administration Assessment" and was dated 09/20/24. In the bottom section of the document, it was documented that R3 could keep certain medications at the bedside per the outside medical provider order. It was handwritten as needed meds in parenthesis, and topical ointment.

Observation at approximately 02:30 PM of R3's room revealed a desk located in the southwest corner of the room. Sitting on top of the right corner of the desk were a tube of Diciofenac gel and a tube of Urea 40% cream.

Interview with Operator/LN A at approximately 03:00PM confirmed R3's FCS identified R3 as unable to perform self-management of his medications/medical treatments.

The Operator failed to ensure that each resident's functional capacity at the time of the screening was accurately reflected on that resident's screening from for R2 and R3.

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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. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (a) The facility reported a census of 18 residents. The sample included 3 "Residents'" (R)1, R2, and R3. Based on record review, interview, and observation, the Operator failed to ensure an assessment was performed for R2 that determined she could perform self-administration of "Over-the Counter" (OTC) medications safely, accurately and without staff assistance. Findings included: - Record review for R2 revealed and admission	S3175		

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S3175	Continued From page 6 date of 03/23/24 with diagnoses of chronic asthma, Diabetes Mellitus type two, macular degeneration, legally blind, and neuropathy. Review of R2's "Functional Capacity Screen" (FCS) dated 03/23/24 revealed R2 required supervision with bathing, dressing, transferring, walking/mobility, and she was unable to perform management of her medications and medical treatments. R1 was frequently incontinent and was marked with impaired memory/recall and impaired decision making. R2 was able to make herself understood and she understood others. R2 was marked at risk for falls, impaired vision, and impaired decision making. R2 used a walker mobility device. Review of R2's combined "Negotiated Service Agreement/Health Service Plan" (NSA/HSP) dated 03/23/24 under the section titled "Medications and Treatments" and "Explanation of what resident administers themselves" was handwritten "nose spray and inhaler and able to utilize". It was marked that the "Self-administration of Medications Assessment" had been completed. Under the section titled "Skilled Nursing service to be provided", "Injections" was marked and handwritten was "Insulin" was four times a day. Under the section titled "Nursing Services to be supervised" the following were marked; Personal Care, Management of Medications, Management of Treatments and Management of behavioral symptoms. The combined NSA/HSP lacked identification of who would administer R2's ordered medications and the management of R2's insulin injections.	S3175		

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S3175	Continued From page 7 Review of R2's medical record revealed a document titled "Medication Self-Administration Assessment" and was dated 08/22/24. The top of the document had eighteen questions on the left side and an area to assess if the resident was "unable, able with assist, or fully capable". The area to answer if the resident ability had handwritten over the area to answer, "See below". In the area for assessment results, it was handwritten "Only keep Flonase Nasal spray in room", it continued to be handwritten that R2 was able to demonstrate how to store and use the Flonase nasal spray in front of the "Licensed Nurse" (LN). Record review of R2's medical providers signed medication orders dated 02/05/25revealed R2 had orders for the following medications and OTC's; Acetaminophen Arthritis 650 "milligram" (mg) tablets 2 tablets at hour of sleep for pain Albuterol Sulfate HFA inhalation Aerosol solution 108 (90 base) 2 puffs every for hours as needed for shortness of breath (may keep at bedside) Alendronate70 mg weekly Basaglar Insulin 35 units subcutaneous every morning Calcium carbonate 600 milligram 1 tablet by mouth every day Cholecalciferol D3 2,000 international units (IU) by mouth every day Diclofenac 50 mg 1 by mouth twice daily Fiasp Insulin follow sliding scale Flonase Nasal Spray 2 sprays each nostril daily Gabapentin 600 mg 1 cap by mouth at hour of sleep	S3175		

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S3175	Continued From page 8 Headache Relief (250 milligram Tylenol, 250 milligram Aspirin, 65 mg caffeine) as needed for pain/headaches Macrobid 100 mg 1 cap by mouth every day Pravastatin 20 mg 1 by mouth at hour of sleep Observation on 3/12/25 at approximately 02:35 PM in R2's bathroom medicine cabinet located on the east wall of the bathroom to the left of the sink were the following OTC medications: 1 bottle of hydrogen peroxide 1 bottle of lidocaine pain relieving cream 1 bottle of Glucose tablets 1 bottle of Tums 1 bottle of Rexall ear relief drops 1 bottle of Equate Nasal spray Interview on 3/12/25 at approximately 02:35 PM with Operator/LN A confirmed the facility manages R2's medications and the only approved OTC medications to be in R2's room were the Flonase and Albuterol inhaler, she continued to confirm she "knew" about the "Tums" and was unaware of the other OTC medications present in the bathroom medicine cabinet. Operator/LN A confirmed R2's "Self-Administration of Medications" did not include the hydrogen peroxide, lidocaine pain relieving cream, glucose tablets, tums or ear relief drops. The Operator failed to ensure an assessment was performed for R2 that determined she could perform self-administration of OTC medications safely, accurately and without staff assistance.	S3175		

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S3186	Continued From page 9	S3186		
S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (b) The facility reported a census of 18 residents. The sample included 3 "Residents'" (R)1, R2, and R3. Based on record review, interview, and observation, the Operator failed to ensure R2 and R3's "Negotiated Service Agreements'" (NSA)'s identified who was responsible for the administration of select medications for R2 and R3. The Operator further failed to identify who was responsible for the dialing of R2's insulin pen. Findings included: - Record review for R2 revealed and admission date of 03/23/24 with diagnoses of chronic asthma, Diabetes Mellitus type two, macular degeneration, legally blind, and neuropathy.	S3186		

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S3186	Continued From page 10 Review of R2's "Functional Capacity Screen" (FCS) dated 03/23/24 revealed R2 required supervision with bathing, dressing, transferring, walking/mobility, and she was unable to perform management of her medications and medical treatments. R1 was frequently incontinent and was marked with impaired memory/recall and impaired decision making. R2 was able to make herself understood and she understood others. R2 was marked at risk for falls, impaired vision, and impaired decision making. R2 used a walker mobility device. Review of R2's combined "Negotiated Service Agreement/Health Service Plan" (NSA/HSP) dated 03/23/24 under the section titled "Medications and Treatments" and "Explanation of what resident administers themselves" was handwritten "nose spray and inhaler and able to utilize". It was marked that the "Self-administration of Medications Assessment" had been completed. Under the section titled "Skilled Nursing service to be provided", "Injections" was marked and handwritten was "Insulin" was four times a day. Under the section titled "Nursing Services to be supervised" the following were marked; Personal Care, Management of Medications, Management of Treatments and Management of behavioral symptoms. The combined NSA/HSP lacked identification of who would administer R2's ordered medications and the management of the dialing of R2's insulin pens. Review of R2's medical record revealed a	S3186		

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S3186	Continued From page 11	S3186		

document titled "Medication Self-Administration Assessment" and was dated 08/22/24. The top of the document had eighteen questions on the left side and an area to assess if the resident was "unable, able with assist, or fully capable". The area to answer if the resident ability had handwritten over the area to answer, "See below". In the area for assessment results, it was handwritten "Only keep Flonase Nasal spray in room", it continued to be handwritten that R2 was able to demonstrate how to store and use the Flonase nasal spray in front of the "Licensed Nurse" (LN).

Record review of R2's medical providers signed medication orders dated 02/05/25revealed R2 had orders for the following medications and OTC's;

Acetaminophen Arthritis 650 "milligram" (mg) tablets 2 tablets at hour of sleep for pain
Albuterol Sulfate HFA inhalation Aerosol solution 108 (90 base) 2 puffs every for hours as needed for shortness of breath (may keep at bedside)
Alendronate70 mg weekly
Basaglar Insulin 35 units subcutaneous every morning
Calcium carbonate 600 milligram 1 tablet by mouth every day
Cholecalciferol D3 2,000 international units (IU) by mouth every day
Diclofenac 50 mg 1 by mouth twice daily
Fiasp Insulin follow sliding scale
Flonase Nasal Spray 2 sprays each nostril daily
Gabapentin 600 mg 1 cap by mouth at hour of sleep
Headache Relief (250 milligram Tylenol, 250 milligram Aspirin, 65 mg caffeine) as needed for

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S3186	Continued From page 12	S3186		

pain/headaches
Macrobid 100 mg 1 cap by mouth every day
Pravastatin 20 mg 1 by mouth at hour of sleep

Observation on 3/12/25 at approximately 02:35 PM in R2's bathroom medicine cabinet located on the east wall of the bathroom to the left of the sink were the following OTC medications:

1 bottle of hydrogen peroxide
1 bottle of lidocaine pain relieving cream
1 bottle of Glucose tablets
1 bottle of Tums
1 bottle of Rexall ear relief drops
1 bottle of Equate Nasal spray

Interview on 3/12/25 at approximately 02:35 PM with Operator/LN A confirmed the facility manages R2's medications and the only approved OTC medications to be in R2's room were the Flonase and Albuterol inhaler, she continued to confirm she "knew" about the "Tums" and was unaware of the other OTC medications present in the bathroom medicine cabinet. Operator/LN A confirmed R2's combined NSA/HSP did not identify who was responsible for the administration of the hydrogen peroxide, lidocaine pain relieving cream, glucose tablets, tums or ear relief drops. Operator/LN A further confirmed the LN would administer R2's insulin if the nurse was in the building at the time of the ordered insulin, Operator/LN A continued to state the "Certified Medication Aides'" (CMA)s would dial the pen and R2 would self-inject the insulin in the LN was not present when the insulin was due for administration.

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S3186	Continued From page 13	S3186		

Record review for R3 revealed an admission date of 04/14/24 with diagnoses of manic bipolar, depression, hypertension, coronary artery disease, systolic heart failure, self-care deficit, congestive heart failure, chronic obstructive pulmonary disease, and unilateral electroconvulsive therapy.

Review of R3's FCS dated 04/14/24 revealed R3 required supervising with bathing and dressing. He was independent with toileting, transferring, walking/mobility and eating. R3 was marked as unable to perform his own medication/medical treatment management. R3 was continent, and had impaired short-term memory, impaired long-term memory, impaired memory/recall and impaired decision making. R3 was usually able to make himself understood and he understood others. R3 was identified at risk for falls and impaired decision making. R3 used no mobility device.

Review of R3's combined NSA/HSP dated 04/14/24 under the section titled "Medications and Treatments" had marked "Staff administration" of his medications and treatments. Under the section titled "Nursing Services to be supervised" the following were marked; Personal Care, Management of Medications, Management of Treatments and Management of behavioral symptoms.

The NSA/HSP lacked identification of who was administering select medications.

Review of R2's medical record revealed a document titled "Medication Self-Administration Assessment" and was dated 09/20/24. In the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ESTATES	329 N KAY LANE PARSONS, KS 67357

(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
S3186	Continued From page 14 bottom section of the document, it was documented that R3 could keep certain medications at the bedside per the outside medical provider order. It was handwritten as needed meds in parenthesis, and topical ointment. The document lacked identification of the medications R3 could keep at the bedside. Observation at approximately 02:30 PM of R3's room revealed a desk located in the southwest corner of the room. Sitting on top of the right corner of the desk were a tube of Diciofenac gel and a tube of Urea 40% cream. Interview with Operator/LN A at approximately 03:00PM confirmed R3's FCS identified R3 as unable to perform self-management of his medications/medical treatments, and she further confirmed R3's NSA/HSP identified staff administration of R3's medications and medical treatments. The Operator failed to ensure R's 2 and 3 NSA's identified who was responsible for the administration of select medications and the Operator further failed to identify who was responsible for the dialing of R2's insulin pen.	S3186		
S3215 SS=D	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and	S3215		

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S3215	Continued From page 15 regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (h) (4) The facility reported a census of 18 residents. Based on observation and interview the Operator failed to ensure the "Licensed Nurse" (LN) and "Certified Medication Aides" (CMA)s did not administer medications beyond the	S3215		

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S3215	Continued From page 16 manufacturer's or pharmacy provider's recommended date of expiration for insulin pens. Findings included: - Observation on 03/12/25 at approximately 09:40 AM, LN A unlocked the facility medication cart located in the medication room and in the top drawer on the left side was a Basaglar Kwick pen that was approximately half full. The Basaglar Kwick pen lacked a date the pen was opened. Review of the Basaglar manufacturer's instructions stated to; Throw away the in-use pen after 28 days, even if it still contained insulin in the pen. Interview on 03/12/25 at approximately 09:40 AM with Operator/ LN A confirmed the Basaglar Kwick pen lacked a date when the pen was opened. The Operator failed to ensure the LN and CMAs did not administer medications beyond the manufacturer's or pharmacy provider's recommended date of expiration for insulin pens.	S3215		
S3220 SS=D	26-41-205 (k) Medication Clinical Record (k) Clinical record. The administrator or operator, or the designee, shall ensure that the clinical record of each resident for whom the facility manages medication or prefills medication containers or syringes contains the following documentation: (1) A medical care provider ' s order for each	S3220		

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S3220	Continued From page 17 medication; (2) the name of the pharmacy provider of the resident ' s choice; (3) any known medication allergies; and (4) the date and the 12-hour or 24-hour clock time any medication is administered to the resident. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (k) (1) The facility reported a census of 18 residents. The sample included 3 "Residents'" (R)1, R2, and R3. Based on record review, interview, and observation, the Operator failed to ensure the facility had a medical care providers order for each medication for R2. Findings included: - Record review for R2 revealed and admission date of 03/23/24 with diagnoses of chronic asthma, Diabetes Mellitus type two, macular degeneration, legally blind, and neuropathy. Review of R2's "Functional Capacity Screen" (FCS) dated 03/23/24 revealed R2 required supervision with bathing, dressing, transferring, walking/mobility, and she was unable to perform management of her medications and medical treatments. R1 was frequently incontinent and was marked with impaired memory/recall and	S3220		

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S3220	Continued From page 18	S3220		

impaired decision making. R2 was able to make herself understood and she understood others. R2 was marked at risk for falls, impaired vision, and impaired decision making. R2 used a walker mobility device.

Review of R2's combined "Negotiated Service Agreement/Health Service Plan" (NSA/HSP) dated 03/23/24, under the section titled "Medications and Treatments" and "Explanation of what resident administers themselves" was handwritten "nose spray and inhaler and able to utilize". It was marked that the "Self-administration of Medications Assessment" had been completed. Under the section titled "Skilled Nursing service to be provided", "Injections" was marked and handwritten was "Insulin" was four times a day. Under the section titled "Nursing Services to be supervised" the following were marked; Personal Care, Management of Medications, Management of Treatments and Management of behavioral symptoms.

The combined NSA/HSP lacked identification of who would administer R2's ordered medications and the management of R2's insulin injections, and further failed to identify which medications R2 would self-administer.

Review of R2's medical record revealed a document titled "Medication Self-Administration Assessment" and was dated 08/22/24. The top of the document had eighteen questions on the left side and an area to assess if the resident was "unable, able with assist, or fully capable". The area to answer if the resident ability had handwritten over the area to answer, "See

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S3220	Continued From page 19	S3220		

below". In the area for assessment results, it was handwritten "Only keep Flonase Nasal spray in room", it continued to be handwritten that R2 was able to demonstrate how to store and use the Flonase nasal spray in front of the "Licensed Nurse" (LN).

Record review of R2's medical providers signed medication orders dated 02/05/25, revealed R2 had orders for the following medications and OTC's;

Acetaminophen Arthritis 650 "milligram" (mg) tablets 2 tablets at hour of sleep for pain
Albuterol Sulfate HFA inhalation Aerosol solution 108 (90 base) 2 puffs every for hours as needed for shortness of breath (may keep at bedside)
Alendronate70 mg weekly
Basaglar Insulin 35 units subcutaneous every morning
Calcium carbonate 600 milligram 1 tablet by mouth every day
Cholecalciferol D3 2,000 international units (IU) by mouth every day
Diclofenac 50 mg 1 by mouth twice daily
Fiasp Insulin follow sliding scale
Flonase Nasal Spray 2 sprays each nostril daily
Gabapentin 600 mg 1 cap by mouth at hour of sleep
Headache Relief (250 milligram Tylenol, 250 milligram Aspirin, 65 mg caffeine) as needed for pain/headaches
Macrobid 100 mg 1 cap by mouth every day
Pravastatin 20 mg 1 by mouth at hour of sleep

Observation on 3/12/25 at approximately 02:35 PM in R2's bathroom medicine cabinet located on the east wall of the bathroom to the left of the

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S3220	Continued From page 20 sink were the following OTC medications: 1 bottle of hydrogen peroxide 1 bottle of lidocaine pain relieving cream 1 bottle of Glucose tablets 1 bottle of Tums 1 bottle of Rexall ear relief drops 1 bottle of Equate Nasal spray Interview on 3/12/25 at approximately 02:35 PM with Operator/LN A confirmed the facility managed R2's medications and the only approved OTC medications to be in R2's room were the Flonase and Albuterol inhaler, and Operator/LN A further confirmed she was aware of R2 having a bottle of Tums in her room. The Operator failed to ensure the facility had a medical care providers order for each medication for R2	S3220		
S3256 SS=F	26-41-105 (c) Resident Records Safeguards (c) Each administrator or operator shall ensure the safeguarding of resident records against the following:(1) Loss; (2) destruction; (3) fire; (4) theft; and (5) unauthorized use. This REQUIREMENT is not met as evidenced by:	S3256		

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S3256	Continued From page 21 K.A.R. 26-41-105 (c) (1) (2) (3) (4) (5) The facility reported a census of 18 residents. Based on observation and interview the Operator failed to ensure the safeguarding of resident records against loss, destruction, fire theft and unauthorized use when the resident medical records were stored in an unlocked beauty shop, in unsecured cabinets. Findings included: - Observation on 03/12/25 at approximately 08:45 AM during the initial facility tour, a placard identified the room as a "Beauty Shop" and the door stood open. On the northeast wall was a counter with lower cabinets, and above the counter were another set of cabinets with the first two doors labeled "A - B", the second two doors were labeled "C-H", the third set of doors were labeled "H-K", the fourth set of doors were labeled "L-N", the fifth set of doors were labeled "R-S", and the last set of doors were labeled "T-2". The doors freely opened, and the cabinets contained a white binder for each of the residents who resided in the Assisted Living community. Interview on 03/12/25 at approximately 09:15 AM with Operator/ LN A confirmed the cabinets in the facility "Beauty Shop" stored each resident's medical record, and she further confirmed the cabinets were not secured. The Operator failed to ensure the safeguarding	S3256		

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S3256	Continued From page 22 of resident records against loss, destruction, fire theft and unauthorized use when the resident medical records were stored in an unlocked beauty shop, in unsecured cabinets.	S3256		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-207 (c) The facility reported a census of 18 residents. The sample included 3 "Residents'" (R)1, R2, and R3 and 5 newly hired employees. Based on record review and interview the Operator failed to ensure the facility's compliance with the department's "Tuberculosis" (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for "Certified Medication Aide" (CMA) B.	S3310		

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S3310	Continued From page 23 Findings included: - Record review for CMA B revealed she began her employment on 11/27/24. The personnel record for CMA B contained the following documents; A document titled "Annual Tuberculosis Symptom Review Questionnaire" dated 10/27/23 revealed at the bottom of the Page the following statement; "Annual recheck; if there is no change since you last filled out his questionnaire please sign and date". CMA B signed her name dated the document 11/27/24 and wrote "rehire". A document titled "Two Step TB Skin Test and Vaccinations" revealed a first step was completed and read negative on 10/30/23. A second step was completed and read negative on 11/10/23. Interview on 03/12/25 at approximately 03:00 PM with Operator/" Licensed Nurse" (LN) A confirmed she did not administer a two step TB test upon CMA B's reemployment with the facility. She further confirmed the date on the completed two step TB skin test was greater then 6 months old at the time of CMA B's reemployment date. The Operator failed to ensure the facility's compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for CMA B.	S3310		
S3320 SS=D	28-39-254 CONSTRUCTION	S3320		

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S3320	Continued From page 24 (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: K.A.R. 28-39-254 (a) The facility reported a census of 18 residents. The sample included 3 "Residents'" (R)1, R2, and R3. Based on observation, record review, and interview the Operator failed to ensure the facility was maintained to protect the health and safety for R2 when located in her room were "Over-the-Counter" (OTC) medications.	S3320		

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S3320	Continued From page 25 Findings included: - Record review for R2 revealed and admission date of 03/23/24 with diagnoses of chronic asthma, Diabetes Mellitus type two, macular degeneration, legally blind, and neuropathy. Review of R2's "Functional Capacity Screen" (FCS) dated 03/23/24 revealed R2 required supervision with bathing, dressing, transferring, walking/mobility, and she was unable to perform management of her medications and medical treatments. R1 was frequently incontinent and was marked with impaired memory/recall and impaired decision making. R2 was able to make herself understood and she understood others. R2 was marked at risk for falls, impaired vision, and impaired decision making. R2 used a walker mobility device. Review of R2's combined "Negotiated Service Agreement/Health Service Plan" (NSA/HSP) dated 03/23/24, under the section titled "Medications and Treatments" and "Explanation of what resident administers themselves" was handwritten "nose spray and inhaler and able to utilize". It was marked that the "Self-administration of Medications Assessment" had been completed. Under the section titled "Skilled Nursing service to be provided", "Injections" was marked and handwritten was "Insulin" was four times a day. Under the section titled "Nursing Services to be supervised" the following were marked; Personal Care, Management of Medications, Management of Treatments and Management of behavioral symptoms.	S3320		

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S3320	Continued From page 26 The combined NSA/HSP lacked identification of who would administer R2's ordered medications and the management of R2's insulin injections. Review of R2's medical record revealed a document titled "Medication Self-Administration Assessment" and was dated 08/22/24. The top of the document had eighteen questions on the left side and an area to assess if the resident was "unable, able with assist, or fully capable". The area to answer if the resident ability had handwritten over the area to answer, "See below". In the area for assessment results, it was handwritten "Only keep Flonase Nasal spray in room", it continued to be handwritten that R2 was able to demonstrate how to store and use the Flonase nasal spray in front of the "Licensed Nurse" (LN). Record review of R2's medical providers signed medication orders dated 02/05/25, revealed R2 had orders for the following medications and OTC's; Acetaminophen Arthritis 650 "milligram" (mg) tablets 2 tablets at hour of sleep for pain Albuterol Sulfate HFA inhalation Aerosol solution 108 (90 base) 2 puffs every for hours as needed for shortness of breath (may keep at bedside) Alendronate70 mg weekly Basaglar Insulin 35 units subcutaneous every morning Calcium carbonate 600 milligram 1 tablet by mouth every day Cholecalciferol D3 2,000 international units (IU) by mouth every day Diclofenac 50 mg 1 by mouth twice daily	S3320		

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S3320	Continued From page 27 Fiasp Insulin follow sliding scale Flonase Nasal Spray 2 sprays each nostril daily Gabapentin 600 mg 1 cap by mouth at hour of sleep Headache Relief (250 milligram Tylenol, 250 milligram Aspirin, 65 mg caffeine) as needed for pain/headaches Macrobid 100 mg 1 cap by mouth every day Pravastatin 20 mg 1 by mouth at hour of sleep Observation on 3/12/25 at approximately 02:35 PM in R2's bathroom medicine cabinet located on the east wall of the bathroom to the left of the sink were the following OTC medications: 1 bottle of hydrogen peroxide 1 bottle of lidocaine pain relieving cream 1 bottle of Glucose tablets 1 bottle of Tums 1 bottle of Rexall ear relief drops 1 bottle of Equate Nasal spray Interview on 3/12/25 at approximately 02:35 PM with Operator/LN A confirmed the facility manages R2's medications and the only approved OTC medications to be in R2's room were the Flonase and Albuterol inhaler. The Operator failed to ensure the facility was maintained to protect the health and safety for R2 when located in her room were OTC medications.	S3320		