STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N105019	A. BUILDING: _____ B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 represents the findings of a resurvey with attached complaint #181149 at the above named assisted living conducted on 02/05/24 and 02/06/24.	S 000		
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 21 residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of over-the-counter medications (OTC's). Findings included: - Observation on 02/05/24 at 03:13 PM revealed Certified Medication Aide (CMA) E unlocked and	S3211		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N105019	A. BUILDING: _____ B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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
S3211	Continued From page 1 opened the east hall medication cart which contained medications for the residents. The following OTC medications lacked resident's full names: One bottle of Kirkland Laxaclear, propylene glycol, 29.9 oz One bottle of vitamin B12 1000 micrograms (mcg) 300 tablets One box of Pepcid 20 milligrams (mg), 25 tablets Observation on 02/05/24 at 03:18 PM revealed CMA B unlocked and opened the west hall medication cart, which contained medications for the residents. The following OTC medication lacked resident's full name: One bottle of Miralax, 45 doses. On 02/05/24 at approximately 03:13 PM CMA E stated the CMA's labeled OTC medications with residents' names. On 02/05/24 at approximately 03:13 PM Administrative Staff C confirmed CMA's labeled OTC medications with residents' names. The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of OTC medications.	S3211		
S3280 SS=F	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	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N105019	A. BUILDING: _____ B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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
S3280	Continued From page 2 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: KAR 26-41-104(d)(3) The facility reported a census of 21 residents. Based on interview and record review the administrator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan with staff and residents were completed. Findings included: - Review of the facility's emergency plan records lacked evidence of documentation quarterly reviews were completed with staff during the third and fourth quarter of 2023 and with residents for all quarters of 2023. On 02/05/24 at 03:46 PM Administrative Staff A confirmed the facility's record lacked documentation reviews of the emergency management plan were completed quarterly with staff and residents.	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N105019	A. BUILDING: _____ B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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
S3280	Continued From page 3 The administrator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan with staff and residents were completed.	S3280		
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: KAR 26-41-207(c) The facility reported a census of 21 residents. Based on interview and record review the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for two out of five sampled staff. Findings included:	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N105019	A. BUILDING: _____ B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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
S3310	Continued From page 4 - Review of Certified Medication Aide (CMA) F's employee record revealed a hire date of 01/16/23 and lacked evidence of documentation of TB testing. Review of CMA G's employee record revealed a hire date of 09/07/23 and lacked evidence of TB testing. On 02/06/24 at approximately 10:19 AM Administrative Staff B confirmed CMA F and G's records lacked evidence of documentation TB testing had been completed according to the department's guidelines. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee shall receive a two-step TB skin test within seven days of employment. The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		