Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	R 01/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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 citation is the result of a Revisit and Correction Order 21-1 at the above named Residential Health Care Facility on 01/27/20 and 01/28/20.	{S 000}		
{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 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 census equaled 16 Residents, the sample included three. The Resident Roster identified 15 Residents of facility as receiving facility management of medications. Based on observations and interview, for one of three sampled (#130) and five non-sampled (#1025, #1026, #1020, #1023, and #1012), the Operator failed to ensure licensed nurses or pharmacists placed the full name of Resident on each package of the Resident's over the counter medication.	{S3211}		

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

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{S3211}	Continued From page 1 Findings included: - Observation on 01/27/20 at 3:15pm revealed a locked medication closet in the living/dining area of the facility. A nearby locked closet between the living/dining area contained overflow medications in separate purple bins for each Resident. The following medications lacked both first and last names: #1030 - one bottle of Vitamin C (supplement) 500mg(milligram) tablets lacked first or last name; three foil packs with 75 punch out doses of Dulcolax (laxative) tablets lacked first or last name #1025 - one bottle Debrox (ear flush) solution lacked first or last name #1012 - one bottle Fluticasone (nasal corticosteroid for allergies) lacked first or last name; one bottle Acetaminophen tablets 325mg (milligrams) with first name only #1023 - one bottle of Aspirin (cardiac prophylaxis) 81mg lacked first or last name; one bottle Fish Oil capsules (supplement) 1000mg with first and last initials on lid #1020 - one bottle Aspirin 81mg lacked first and last name; one bottle Loratidine (allergies) 10mg tablets lacked first and last name #1026 - one bottle Milk of Magnesia (laxative), lacked first or last name On 01/27/20 at 3:15pm, Facility Nurse #B confirmed these items lacked first and last name... stated most of these were marked on the outside box upon arrival at facility, but separated from the marked box when placed in the medication cart... confirmed first and last name routinely placed on the outside box only up to this time.	{S3211}		

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{S3211}	Continued From page 2 The Operator failed to ensure licensed nurses or pharmacists placed the full name of Resident on each package of the Resident's over the counter medication.	{S3211}		