

Survey, Certification and Credentialing Commission
612 S. Kansas Avenue
Topeka, KS 66603



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wwwmail@kdads.ks.gov
www.kdads.ks.gov

Kari M. Bruffett, Secretary
Audrey Sunderraj, Interim Commissioner

Sam Brownback, Governor

IMMEDIATE JEOPARDY ABATED

12/04/2015

Provider No. 175346

Debra Salyers, Administrator
Alma Manor
234 Manor Circle
Alma, KS 66401-0127

LICENSURE AND CERTIFICATION SURVEY

On November 30, 2015, a Health survey was concluded at your facility by the Kansas Department for Aging & Disability Services (KDADS) to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety from November 15, 2015 through and including November 18, 2015 for F323 CFR 01-483.25(h).

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Enforcement Remedies

Required remedies will be recommended for imposition by the Center for Medicare & Medicaid Services (CMS) if your facility has failed to achieve substantial compliance. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended. The outcome of a revisit may result in a change in the remedy selected.

As a result of the survey findings and in accordance with 42 CFR 488.417(b), a denial of payment for new Medicare and Medicaid admissions (DPNA) will be imposed effective **December 24, 2015**. We are advising the State Medicaid Agency to deny payment for new admissions effective December 24, 2015. This DPNA will remain in effect until your facility has achieved compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

We are recommending that your provider agreement be terminated on May 30, 2016, if substantial compliance is not achieved by that time.

CMS will notify your facility of any additional remedies to be imposed.

NOTE: The above remedies are subject to change if substantial compliance is not achieved following subsequent visits.

Due to your facility's current noncompliance with F314, Pressure Ulcers, we would like to emphasize the importance of the implementation of corrective actions that ensure that avoidable pressure ulcers will not occur at your facility and that residents will receive appropriate care and services to prevent the increase in complexity of existing pressure ulcers. The pain, infection rates, and increased morbidity and mortality associated with pressure ulcers underscore the need for your facility to improve its systems for identifying residents at risk and for implementing preventive services. We ask that you carefully monitor your facility's compliance with Federal requirements related to the prevention of pressure ulcer development. We suggest that you consider contacting the Quality Improvement Organization (QIO) in your state for

information and training opportunities on pressure ulcer care and prevention. If noncompliance continues in this area, additional remedies will be considered.

Appeal Rights

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than 60 (sixty) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice.** A copy of the hearing request shall be submitted electronically to the Kansas City Regional Centers for Medicare & Medicaid services at:

[IA_KS \(IA_KS_LTCEnforcement@cms.hhs.gov\)](mailto:IA_KS_IA_KS_LTCEnforcement@cms.hhs.gov)

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense.

If you have any questions regarding this matter, please contact Jane Weiler, CMS by phone at (816) 426-2011.

Plan of Correction

At the conclusion of the survey, you were provided a CMS-2567L (Statement of Deficiencies) which listed the deficiencies found at this survey. You should submit your Plan of Correction online at www.kdads.ks.gov. An acceptable Plan of Correction will constitute a credible allegation of compliance. The Plan of Correction must contain the following in order to be acceptable:

- c: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- d: Address how the facility will identify other residents having the potential to be affected by the same deficient practice
- e: Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur
- f: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: (the facility must develop a plan for ensuring that correction is achieved and sustain) and,
- g: Include the dates corrective action was completed.

Substandard Quality of Care

Your facility's noncompliance with F323"J" CFR 01-483-25(h) has been determined to be Substandard Quality of Care as defined at CFR 488.301. Sections 1819(G)(5)(C) and 1919(G)(5)(C) of the Social Security Act and 42 CFR 488.325(H) require that we notify the State Board responsible for licensing the facility's administrator of the substandard quality of

care. Your facility's Medical Director and the attending physician of each resident who was found to have received substandard quality of care should be notified.

Please note that Federal law, as specified in the Social Security Act 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (CEP) offered by or in a facility which, within the previous two years has operated under an 1819(B)(4)(C)(ii)(II) or 1919(b)(4)(C)(ii) waiver, has been subject to the following: an extended or partial extended survey; assessment of a Civil Money Penalty of not less than \$5,000; or, a denial of payment, or termination. If any of these situations occur, NATCEP is to be denied, and you will be so advised in a separate notification. NATCEP will be prohibited since an extended or partial extended survey was conducted at your facility. You will be provided further information regarding this matter from Health Occupations Credentialing with KDADS.

Informal Dispute Resolution (IDR)

In accordance with CFR 488.331, you have one opportunity to question newly identified deficiencies or a different example of a previously cited deficiency through an informal dispute resolution (IDR) process. You may also contest scope and severity assessments for deficiencies that resulted in a finding of substandard quality of care or immediate jeopardy. To be given such an opportunity, you are required to send five copies of your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute substandard quality of care or immediate jeopardy) to:

Audrey Sunderraj, Interim Commissioner
Survey, Certification and Credentialing Commission
Kansas Department for Aging & Disability Services
612 South Kansas Avenue
Topeka, KS 66603

KDADS must receive your written request for IDR within 10 calendar days of your receipt of the statement of deficiencies. An incomplete IDR process will not delay the effective date of any enforcement action. If you have any questions concerning the instructions contained in this letter, please contact me at (785) 368-7055.

Sincerely,



Irina Strakhova
Enforcement Coordinator
Survey, Certification, and Credentialing Commission
Kansas Department for Aging & Disability Services

As Authorized by Darla McCloskey, Branch Manager
Division of Survey & Certification
Centers for Medicare & Medicaid Services

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Susan Fout, KDADS, Regional Manager
Jane Weiler, Survey & Certification Branch, CMS Regional Office, Kansas City, MO
Audrey Sunderraj, Interim Commissioner, KDADS
LaNae Workman, KDADS
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