STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 01/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with complaint's 3152483 and 151331, for the above named facility conducted on 01/07/2021, 01/12/2021, 01/13/2021, 1/14/2021, 1/18/2021, 1/19/2021 and 1/20/2021.	S 000		
S5105 SS=D	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202 (a) (1) (2) (3) The facility reported a census of 8 residents. The sample included 3 residents. Based on interview and record review the operator failed to identify outside provider services and identification of person financially responsible for outside services for resident #101 on the resident negotiated service agreement.	S5105		

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

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S5105	Continued From page 1 Findings included: - Record review for resident # 101 revealed and admission date of 01/29/2020 with diagnoses of acute chronic respiratory failure, dementia, and chronic urinary tract infections. The annual functional capacity screening (FCS) dated 5/25/2020 identified the resident with impaired cognition and marked as unable to perform and needed physical assistance with all activities of daily living, he lacked the ability to manage own medications had a fall risk and used a walker assistive device The unsigned admission negotiated service agreement (NSA) dated 1/29/2020 included the following services provided by the facility: facility would manage medications, provide skin assessments, and assist with personal care, and used 1 person assist with walker for transfers. The health service plan (HSP) dated 5/25/2020 directed staff to assist with showers and dressing, transfer assist with 1 staff, gait belt and walker. Resident identified as a fall risk; instructions for bed to be in lowest position, fall mat and pressure alarm in place. Review of the nursing notes between 2/14/2020 and 12/31/2020 revealed the following entries: 12/31/2020 at 8:05 am staff documented resident running a fever and hospice nurse was notified. 12/21/2020 at 6:00 pm staff documented hospice nurse in the facility with resident. Review of interdisciplinary notes dated 6/17/2020 and 11/10/2020 from hospice provider revealed the resident had an admission to hospice	S5105		

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S5105	Continued From page 2 services on 1/29/2020. Interview on 1/13/2021 at 3:11 pm with licensed nurse C and certified medication aide B confirmed the negotiated service agreement lacked the identification of hospice as an outside provider and the responsible financial party for the services. The operator failed to identify outside provider services and identification of person financially responsible for outside services for resident #101 on the resident negotiated service agreement.	S5105		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (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 home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' 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 26-42-104 (d) (3) (4)	S5215		

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S5215	Continued From page 3 The facility reported a census of 8 residents. Based on interview and record review the operator failed to provide quarterly emergency and disaster preparedness training to staff and residents and failed to conduct the annual evacuation drill. Findings included: - Record review on 1/19/2021 at 3:45 pm revealed the following documents; an Inservice training performed on 6/17/2020 which included the following topics; tornado and fire policy, procedure for reporting abuse, neglect and exploitation, COVID-19 update, falls and fall prevention, medication and narcotic storage, when to call the nurse on call, misappropriation of property, fire procedure, and the employee sign in sheet. Record review on 1/19/2021 at 3:45 pm revealed a fire drill report for the year of 2019, with the last drill recorded on 12/11/2019. Record review on 1/19/2021 at 3:45 pm revealed a fire drill report dated 1/30/2019. Interview on 1/7/2021 at 10:00 am with licensed nurse A revealed during the entrance interview; she was unable to provide documentation for the emergency preparedness training and evacuation drill and she would proceed to look for documentation. Interview on 1/13/2021 at 3:11 pm with licensed nurse C and certified medication aide B, confirmed the documentation lacked quarterly emergency and disaster preparedness training to staff and residents, and failed to conduct the annual evacuation drill.	S5215		

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S5215	Continued From page 4 Interview on 1/19/2021 licensed nurse A confirmed the lack of documentation for emergency and disaster preparedness and the annual evacuation drill for the year 2020 and the documentation provided was for the year 2019.	S5215		
S5230 SS=F	26-42-207 (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; (c) Each administrator or operator shall ensure the home ' 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 26-42-207 (c) The facility reported a census of 8 residents. The sample included 3 residents and 5 sampled employees. Based on interview and record review for 5 newly hired employees, licensed nurse's A and C, certified medication aide (CMA) B, and certified nurse aide's D, E and F, and 3 of 3 sampled residents (#101, #201 and #301) the operator failed to ensure the facility remained in compliance with the department's tuberculosis	S5230		

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S5230	Continued From page 5 guidelines for adult care homes adopted by reference in KAR-26-39-105 with the potential to affect all residents. Findings included: - Review of licensed nurse A personnel record revealed no recorded hire date, verification of license dated 1/14/2020. The employee record lacked evidence of the 2-step tuberculin (TB) test. The file contained an undated TB screening questionnaire that stated the employee shall complete the screening questionnaire and the 2-step skin test no later than 7 days after employment at the top of the screening document. Review of licensed nurse C personnel record revealed she began employment on 9/8/2020. The employee record lacked the second step of the 2-step tuberculin skin test within 7 days of employment. Review of certified nurse aide D personnel record revealed she began employment on 1/12/2021. The employee record lacked the tuberculin (TB) screening questionnaire and the 2-step TB skin test within 7 days of employment. Review of certified nurse aide E personnel record revealed she began employment on 1/2/2021. The employee record lacked the tuberculin (TB) screening questionnaire and the 2-step TB skin test within 7 days of employment. Review of certified nurse aide F personnel record revealed she began employment on 9/12/2020. The employee record lacked the tuberculin (TB) screening questionnaire and the 2-step TB skin test within 7 days of employment	S5230		

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S5230	Continued From page 6 Record review for resident #101 revealed an admission date of 1/29/2020. The resident record lacked evidence of the tuberculin screening questionnaire and 2 step testing within 7 days of admission. Record review for resident #201 revealed an admission date of 2/1/2018. The resident record lacked evidence of the tuberculin screening questionnaire and 2 step testing within 7 days of admission. Record review for resident #301 revealed an admission date of 7/15/2019. The resident record lacked evidence of the tuberculin screening questionnaire and 2 step testing within 7 days of admission. Interview on 1/13/2021 at 3:15 pm with licensed nurse C and certified medication aide B confirmed the personnel files for 5 employees and the resident records for resident's #101, #201 and #301 lacked documentation for the required screening questionnaire and 2 step tuberculin skin tests. The operator 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 with the potential to affect all residents for 5 newly hired employees, licensed nurse's A and C, certified medication aide B, and certified nurse aide's D, E and F, and 3 of 3 sampled residents (#101, #201 and #301) .	S5230		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records	S5258		

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S5258	Continued From page 7 (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102 (d) (2) (3) The facility reported a census of 8 residents. Based on interview and record review the operator failed to have evidence of verification from certified nurse aide registry for 2 of 3 certified staff reviewed (certified nurse aides E and F), and verification of a background check performed for 3 of 3 certified staff (certified nurse aides D, E, and F), pursuant to K.S.A 39-970, to ensure the individual did not have a finding of abuse/neglect/exploitation. All 3 certified staff had the potential to provide care to all residents.	S5258		

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S5258	Continued From page 8 Findings included: - Personnel record review on 1/13/2021 at 11:37 am revealed for certified nurse aide (CNA) D, she began employment on 1/12/2021. The personnel file lacked the evidence the background check had been performed; the file lacked the background check documentation. Personnel record review on 1/13/2021 at 11:37 am revealed for certified nurse aide (CNA) E, she began employment on 1/2/2021. The personnel file lacked the evidence the nurse aide registry verification was conducted, the personnel file lacked the document. The background check provided did not meet K.S.A 39-970 requirements. Personnel record review on 1/12/2021 at 11:37 am revealed for certified nurse aide (CNA) F, she began employment on 9/12/2020. The personnel file lacked the evidence the background check had been performed; the file lacked the background check documentation. Interview on 1/13/2021 at 3:11 pm with licensed nurse C and certified medication aide B confirmed the employee files lacked the background and nurse aide registry checks. The operator failed to have evidence of verification from the certified nurse aide registry for 2 if 3 certified staff reviewed (certified nurse aides E and F), and verification of a background checks performed for 3 of 3 certified staff (certified nurse aides D, E, and F), pursuant to K.S.A 39-970, to ensure the individual did not have a finding of abuse/neglect/exploitation. All 3 certified staff had the potential to provide care to	S5258		

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S5258	Continued From page 9 all residents.	S5258		
S5313 SS=E	26-42-205 (g) (3) Over the counter medication (g) (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 26-42-205 (g) (3) The facility reported a census of 8 residents. Based on observation and interview the operator failed to ensure the over the counter medications (OTC), had the resident's first and last name placed on the package by the licensed nurse for residents #101, #401, #501 and #601. Findings included: - Observation on 1/7/2021 at 12:55 pm with certified medication aide B revealed: she opened the locked medication cart and the following over the counter medication (OTC) bottles were observed;, 1 box of Pataday with the first initial and partial last name of resident #101 and, jar of	S5313		

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S5313	Continued From page 10 U-TRI with the first name of resident #101, 1 box of Kroger eye drops with the first initial and last name for resident #401,1 bottle of fiber powder with first name only of resident #501, I box gen teal with the first name of resident #601. The following OTC bottles lacked any resident identifiers: 1 bottle of Turmeric Curcumin, 1 bottle equate vision formula, 1 bottle equate complete vitamins, 1 bottle arthritis pain 650mg, 2 boxes of allergy relief tablets. Interview on 1/7/2021 at 12:55 pm with medication aide B, she confirmed the over the counter medication containers lacked the resident first and last names for resident #101, #401, #501 and #601. Interview on 1/7/2021 at 1:00 pm with licensed nurse A confirmed the over the counter medications should have the resident first and last names placed by a licensed nurse or licensed pharmacist. The operator failed to ensure the over the counter medications (OTC), had the resident's first and last name placed on the package by the licensed nurse or pharmacist for residents #101, #401, #501 and #601.	S5313		
S5315 SS=D	26-42-205 (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 regulations. (1) Licensed nurses or medication aides shall	S5315		

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S5315	Continued From page 11 store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home 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 home. (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: KAR 26-42-205 (h) (1) The facility reported a census of 8 residents. Based on observation and interview the operator failed to store medications and biologicals in a locked medication room. Findings included: - Review of the resident roster on 1/7/2021 at 11:00 am provided by licensed nurse A, identified	S5315		

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S5315	Continued From page 12 7 residents to be cognitively impaired. Observation on 1/7/2021 at 10:00 am during the initial facility tour revealed the medication room door standing open with a punch code lock, there were 2 bottles of unlabeled over the counter medications on the counter on the west wall. Interview with licensed nurse A on 1/7/2021 at 11:00 am, she confirmed 7 residents are cognitively impaired, with one being independently mobile. Licensed nurse A confirmed the medication room door should be closed. The operator failed to store medications and biologicals in a locked medication room with the potential to affect 1 cognitively impaired and independently mobile resident.	S5315		
S5335 SS=F	28-39-437 Construction (a) Each home-plus 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. This REQUIREMENT is not met as evidenced by: KAR 28-39-437 (a) The facility reported a census of 8 residents with 7 being cognitively impaired, 1 of which was	S5335		

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S5335	Continued From page 13 independently mobile. Based on observation and interview the operator failed to ensure the facility was maintained to protect the health and safety of the residents, personnel and public in regard to unlocked chemicals and unsecured oxygen cylinders. Findings included: - Observation on 1/7/2021 at 9:40 am during the unguided facility tour revealed the laundry room door standing open, with 2 large containers of laundry detergent sitting on the counter. In the common room between room doors at the north west corner of the facility sat an unsecured tall oxygen cylinder with tubing and regulator attached. Interview 1/7/2021 at 9:45 am with licensed nurse A confirmed the facility had 1 independently mobile and confused resident., licensed nurse A confirmed the laundry detergent should be locked and the oxygen cylinder is to be in an oxygen cylinder stand. The operator failed to ensure the facility was maintained to protect the health and safety of the residents, personnel and public in regard to unlocked chemicals and unsecured oxygen cylinders.	S5335		
S9999	Final Observations S/S E KAR 26-42-103(c) The facility reported a census of 8 residents. Based on observation, interview and record review the operator failed to ensure orientation	S9999		

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S9999	Continued From page 14	S9999		

and regular Inservice education for all employees to include dementia training annually for treatment and appropriate response to persons who exhibit behaviors associated with dementia for 3 sampled residents (#101, #201 and #201) with the potential to affect 7 of the residents identified with cognitive impairment.

Findings included:

- Record review 1/7/2020 at 10:00 am, facility provided the resident roster which identified 7 residents with cognitive impairment.

Record review on 1/13/2021 at 3:00 pm revealed the following resident # 101 revealed an admission date of 01/29/2020 with diagnoses of acute chronic respiratory failure, dementia, and chronic urinary tract infections.

Record review on 1/13/2021 at 3:00 pm revealed the following for resident #201; an admission date of 2/1/2018 with diagnoses of urinary tract infections, hypertension, coronary artery disease, dementia and osteo arthritis.

Record review on 1/13/2021 at 3:00 pm revealed the following for resident #301; an admission date of 7/15/2019 with a diagnosis of dementia.

Record review on 1/19/2021 at 3:45 pm revealed the following documents; an Inservice training performed on 6/17/2020 which included the following topics; tornado and fire policy, procedure for reporting abuse, neglect and exploitation, COVID-19 update, falls and fall prevention, medication and narcotic storage, when to call the nurse on call, misappropriation of property, fire procedure, and the employee sign in sheet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 01/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(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
S9999	Continued From page 15 The documentation of Inservice Training lacked documentation of provision of staff education at orientation and annually on the treatment and appropriate response to persons who exhibit behaviors associated with dementia. Interview on 1/13/2021 at 3:15 pm with licensed nurse C and certified nurse aide B confirmed the facility had 7 residents that were cognitively impaired, and 1 resident which was cognitively impaired and independently mobile. Interview on 1/19/2021 at 3:45 pm with licensed nurse A confirmed the facility Inservice dated 6/17/2020 lacked employee education on dementia training. The operator failed to ensure orientation and regular in-service education for all employees to include dementia training annually for treatment and appropriate response to persons who exhibit behaviors associated with dementia for residents #101, #201, #301 and the potential to affect 7 cognitively impaired residents.	S9999		