Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N029005	A. BUILDING: _____ B. WING _____	C 10/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR OF THE PLAINS	200 CAMPUS DRIVE DODGE CITY, KS 67801

(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 a resurvey with complaint #147791 for the above named facility conducted on 10/20,21,22/2020.	S 000		
S3280 SS=E	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 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 13 residents. Based on record review and interview for all residents in the facility, the administrator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with with all residents.	S3280		

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
	N029005	A. BUILDING: _____ B. WING _____	C 10/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR OF THE PLAINS	200 CAMPUS DRIVE DODGE CITY, KS 67801

(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 1 Findings included: - Review of the resident council minutes provided on 10-21-20 lacked mention of review of the 8 required areas for disaster preparedness with residents who lived in the facility. Review of the emergency management reviews provided by environmental staff H included review of fire monthly with the monthly fire drills. He also provided evidence of completion of an annual review of tornado/ severe weather plan. During an interview on 10-21-20 at 2:43 PM environmental staff H stated that with the COVID-19 they had not been doing community gatherings for training related to the emergency management plan. He stated we do monthly fire drills and discuss education during each fire drill. For all residents the administrator failed to ensure emergency preparedness by ensuring quarterly review of all required areas of the emergency management plan with residents.	S3280		
S3310 SS=E	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	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N029005	A. BUILDING: _____ B. WING _____	C 10/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR OF THE PLAINS	200 CAMPUS DRIVE DODGE CITY, KS 67801

(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 2 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 13 residents. Based on interview and record review for 3 of 5 newly hired employees the administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Review of 5 newly hired employees file revealed the following: Licensed nursing staff C hired onto the facility on 3-4-20 and the record lacked a Tuberculosis (TB) symptom screen completed upon hire. Certified staff F hired onto the facility on 5-13-19 and the record lacked a TB symptom screen completed upon hire. Certified staff G hired onto the facility on 1-29-20 and the record lacked a TB symptom screen completed upon hire. On 10-21-20 at 12:26 PM licensed nursing staff C reported our policy for TB testing directs the nurse to give all new staff a TB skin test so we no longer do the screens	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N029005	A. BUILDING: _____ B. WING _____	C 10/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR OF THE PLAINS	200 CAMPUS DRIVE DODGE CITY, KS 67801

(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 3 Review of the June 2013 TB guidelines for adult care homes revealed that each new resident and new employee shall have an initial TB symptoms screen that includes the components of the TB symptom screen questionnaire within 7 days of residency or employment. Review of the facilities Immunization for TB policy dated 7-18-2019 directed staff to - "At New Hire/Volunteer 1. Complete Baseline Individual TB Risk Assessment" ... For Resident "i Admission - "Complete the TB Baseline Individual Risk Assessment at admission and annually." For 3 of 5 newly hired employees the administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		