STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039005	A. BUILDING: _____ B. WING _____	09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ESTATES ASSISTED LIVING	1212 HICKORY STREET HARPER, KS 67058

(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 the resurvey for the above named facility conducted on 9/8,9,10/2020..	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility 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 26-41-202(a)(1)(2)(3) The facility reported a census of 9 residents. The resident sample included 3 residents and 2 focused record reviews. Based on observation, interview and record review the operator failed to ensure 2/5 (#908, #911) residents negotiated service agreements included a description of the services each resident would receive related to	S3085		

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

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S3085	Continued From page 1 physical therapy services, and hand rails used as an assistive device. Findings included: - Review of resident #908's medical record revealed she admitted to the facility on 9-18-19 with diagnoses of left hip fracture and hypertension. Review of the resident's functional capacity screen (FCS) dated 9-12-19 revealed the resident required supervision with walking and used a walker as an assistive device. It also had written on it the resident would receive physical therapy for gait training and strengthening. Review of the negotiated service agreement dated 9-18-19 lacked information regarding outside services related to physical therapy, who would provide the service and who would pay for the service. The negotiated service agreement also did not include the resident used a hand rail for assistance with bed mobility. Review of the residents medical record lacked notes from the home health agency that provided therapy services or nurses notes regarding how resident was tolerating / progressing with therapy. Review of the residents nurses monthly notes revealed the following: 9-25-19 noted the resident received home health services from a local agency 2 times a week for occupational therapy. 10-2-19 noted the resident received home health services from the same agency 2 times a week for physical therapy.	S3085		

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S3085	Continued From page 2 11-6-19 noted that physical therapy saw the resident twice a week. The nurses notes lacked documentation of when the resident started therapy or when the resident completed therapy services. Observation on 9-8-20 at 2:28 PM revealed an upside down U shaped hand rail on the north side of the resident's bed. The rail fit tight up against the mattress and was secure to the bed. However, The gap between the rails were greater than 4 inches. During an interview on 9-9-20 at 7:56 AM operator A confirmed there were no therapy notes in the resident record and had no other documentation in record regarding therapy services other than the nurses notes. During an interview on 9-9-2020 at 10:51 PM Operator A confirmed the resident had hand rails on her beds but did not realize they needed to be part of the NSA. She stated she had not completed an assessment for safety of the hand rail and resident use of it. - Review of resident #911's medical record revealed the resident admitted to the facility on 5-10-15 with diagnoses of debility related to cerebral anoxia. Review of the residents FCS dated 6-24-20 revealed the resident was independent with activities of daily living and used a cane and walker as an assistive device. Review of the resident's NSA/HCSP dated 6-24-20 failed to identify the resident used a	S3085		

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S3085	Continued From page 3 hand rail for assistance with bed mobility. Observation on 9-8-20 at 2:35 PM of the resident's apartment revealed he had an upside down U shaped hand rail on the west side of his bed that fit tight against the bed. However, the gap distance between the rails is greater than 4 inches. During an interview on 9-8-20 at 2:36 PM the resident stated he used the rail to keep from falling out of bed. He stated he also used it to help get out of bed in the mornings. During an interview on 9-9-2020 at 10:51 PM Operator A confirmed the resident had hand rails on her beds but did not realize they needed to be part of the NSA. She stated she had not completed an assessment for safety of the hand rail and resident use of it. The operator failed to ensure resident #908 and #911's negotiated service agreement included a description of the services each resident would receive related to all aspects of outside resource to provide physical therapy services, and hand rails used as an assistive device.	S3085		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives	S3092		

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S3092	Continued From page 4	S3092		

assistance with eating from a paid nutrition assistant; and
(4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-202(d)(2)

The facility reported a census of 9 residents. The sample included 3 residents and 2 focused record reviews. Based on observations, interview and record review the operator failed to ensure the revision of 1 (#910) of 3 sampled residents negotiated service agreements following a significant change in condition, as defined in KAR 26-39-100.

Findings included:

- Review of resident #910's medical record revealed the resident admitted to the facility on 10-7-15 with diagnoses of hypertension and arthritis.

The residents functional capacity screen dated 6-24-20 revealed the resident was independent with dressing and mobility and did not identify the resident used a wheelchair for an assistive device.

The residents negotiated service agreement dated 6-24-20 did not identify staff assisted the resident with dressing, putting on and off socks and shoes or used a wheelchair for a mobility

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S3092	Continued From page 5 devise with staff assistance to meals. Observation on 9-9-20 at 11:00 AM revealed certified nurse aide C brought the resident over to the main building from her apartment via wheelchair. Staff physically pushed the resident in the chair. During an interview on 9-9-20 at 12:13 PM certified nurse aide B stated staff put on the residents shoes and socks and then take them off in the evening. Staff B stated the resident uses the wheelchair to come over for meals and staff push her because it is easier for her. During an interview on 9-9-20 at 12:14 the resident reported she used the wheelchair because she had a bad hip but used the walker in her apartment. During an interview on 9-9-20 at 12;02 PM operator A reported the resident used the wheelchair for awhile now because it just hurts for her to walk from her apartment to the dining room. Staff A stated she did not realize staff were putting on the resident's shoes and socks. Staff A confirmed the negotiated service agreement needed to be revised. The operator failed to ensure the revision of resident #910's negotiated service agreements following a significant change in condition, as defined in KAR 26-39-100.	S3092		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the	S3200		

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S3200	Continued From page 6 administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(1) The facility reported a census of 9 residents. The sample included 3 residents and 2 focused record reviews. Based on observation, record review, and interview the operator failed to ensure 3 resident's (#909, #911, #912) who the facility staff assisted with administration of their medications were administered in accordance with a medical care provider's written order and according to professional standards of practice. The operator also failed to ensure that only a licensed nurses and medications aides administered and managed the medications for these residents. Findings included: - Review of resident #909's medical record	S3200		

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S3200	Continued From page 7 revealed she admitted to the facility on 4-1-12 with diagnoses of cerebral degeneration, hypertension, unsteady gait, anxiety and vertigo. Review of the resident's functional capacity screen (FCS) dated 10-2-19 revealed the resident required supervision with management of medications and treatments. Review of the resident's negotiated service agreement/health care service plan (NSA/HCSP) dated 10-4-19 revealed the staff provided the resident medication reminders due to not taking them correctly and the medications are bubble packed from local pharmacy. Review of the residents record included a medication self administration assessment dated 10-2-19 which noted the resident could open and close containers with staff assistance and the resident received medication reminders from staff. Review of the form staff used to initial assisting resident's with medications included the initials of certified nurse aide B, certified nurse aide C, certified nurse aide E, and certified nurse aide D. During an interview on 9-9-20 at 9:45 AM certified nurse aide B stated the X on the flow sheet meant staff assisted the resident with giving medications and the person who helped give the medications initialed under the X. Review of the resident's record included a medication list dated 7-1-20 that lacked a medical providers signature. The record lacked additional current orders for the resident's medications.	S3200		

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S3200	Continued From page 8 Observation of the unlocked medication cart on 9-8-20 at 1:09 PM included bubble packed medications for the resident. The unlocked medication cart was accessible to certified nurse aides. During an interview on 9-8-20 at 2:29 PM certified nurse aide B reported for resident #909 she got resident's medication out of the cart and would pop them out of the card, put in a medication cup and then hand them to the resident to take. During an interview on 9-8-20 at 2:31 PM certified nurse aide C reported she had helped the resident with her medication and they hand her the card and help the resident punch them out into a cup. Staff C stated the resident is not strong enough to punch them out on her own. During an interview on 9-9-20 at 10:51 AM Operator A confirmed the resident did not have current signed medical providers orders for the medication. The operator failed to ensure resident #909's medications were administered in accordance with a medical care provider's written order and failed to ensure that only a licensed nurse or medication aide administered medications to resident #909. - Review of resident #911's medical record revealed the resident admitted to the facility on 5-10-15 with diagnoses of debility related to cerebral anoxia.	S3200		

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Review of the residents FCS dated 6-24-20 revealed the resident needed supervision with medication administration and could not administer medication treatments.

Review of the resident's NSA/HCSP dated 6-24-20 revealed a local pharmacy bubble packed the resident's medications and the facility staff provided medication reminders.

Review of the resident's medication self-administration assessment dated 6-24-20 revealed the resident could administer eye drops and ointments with staff assistance.

Review of the form staff used to initial assisting resident's with medications included the initials of certified nurse aide B, certified nurse aide C, certified nurse aide E, and certified nurse aide D.

During an interview on 9-9-20 at 9:45 AM certified nurse aide B stated the X on the flow sheet meant staff assisted the resident with giving medications and the person who helped give the medications initialed under the X.

Review of the resident's record included a medication list dated 7-1-20 that lacked a medical providers signature. The record lacked additional current orders for the resident's medications.

Observation of the unlocked medication cart on 9-8-20 at 1:09 PM included strip packaging for the resident's medications. The unlocked medication cart was accessible to certified nurse aides.

During an interview on 9-9-20 at 9:45 AM

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certified nurse aide B and certified nurse aide C stated the nurse aides would give the resident his eye drops because the resident could not do it himself. Certified nurse aide B stated the X on the flow sheet meant staff assisted the resident with giving medications and the person who helped give the medications initialed under the X.

During an interview on 9-9-20 at 10:51 AM Operator A confirmed the resident did not have current signed medical providers orders for the medication.

The operator failed to ensure resident #911's medications were administered in accordance with a medical care provider's written order and failed to ensure that only a licensed nurse or medication aide administered medications to resident #911.

- Review of resident #912's medical record revealed she admitted to the facility on 4-11-18 with diagnoses of coronary artery disease, thyroid disease, hypertension and edema.

Review of the resident's FCS dated 6-24-20 revealed the resident required supervision with medication administration and physical assistance of management of medical treatments.

Review of the residents NSA/HCSP dated 6-24-20 revealed the resident's medications were bubble packed by local pharmacy and facility staff will do medication reminders.

Review of the form staff used to initial assisting

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resident's with medications included the initials of certified nurse aide B, certified nurse aide C, certified nurse aide E, and certified nurse aide D.

During an interview on 9-9-20 at 9:45 AM certified nurse aide B stated the X on the flow sheet meant staff assisted the resident with giving medications and the person who helped give the medications initialed under the X.

Review of the resident's record included a medication list dated 7-1-20 that lacked a medical providers signature. The record lacked additional current orders for the resident's medications. The list of medications did not include the Lisinopril 2.5 mg that was in the medication cart.

Observation of the unlocked medication cart on 9-8-20 at 1:09 PM included strip packaging for the resident's medications. The unlocked medication cart was accessible to certified nurse aides.

During an interview on 9-8-20 at 2:29 PM certified nurse aide B reported for resident #912 she got the resident's medication out of the cart and would pop them out of the card, put in a medication cup and then hand them to the resident to take.

During an interview on 9-8-20 at 1:09 PM Operator A reported the medication cart should be kept locked. Stated it was probably because staff just finished helping with lunch medications. Observation revealed the cart had medication for resident #909, #911, and #912. Operator A also stated staff provided medication reminders for the 3 residents. She stated the certified nurse

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S3200	Continued From page 12 aides were supposed to get the medications out of the cart and then hand the prefilled cards to the resident for the resident to pop out into a cup and then take. During an interview on 9-9-20 at 10:51 AM Operator A confirmed the resident did not have current signed medical providers orders for the medication. The operator failed to ensure resident #909, #911, and #912's medications were administered in accordance with a medical care provider's written order and standards of practice. The operator also failed to ensure that a licensed nurse or medication aide administer and managed the residents medications who required staff assistance with administration.	S3200		
S3215 SS=E	26-41-205 (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 store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility 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.	S3215		

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S3215	Continued From page 13 (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 facility. (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 26-41-205 (h)(1) The facility reported a census of 8 residents. Based on observation and interview the operator failed to ensure only licensed nurses and medication aides shall have access to the stored medications and biologicals. Findings included: - Observation on 9-8-20 at 12:17 PM revealed a closet in the hall that was unlocked that contained multiple medical items including a tube of cortizone cream, tube of tripple antibiotic ointment, tube of Itch X and a bag of cough drops and jar of petroleum jelly without a name on them. It also contained an accordian puffer with powder medication in it.	S3215		

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S3215	Continued From page 14 On 9-8-20 at 12:25 PM operator A stated the tubes of medications were what she used on her arms but most of it was what the hospital left when they moved into the new hospital. She also stated the door to that closet was supposed to be locked at all times. Observation of the medication cart on 9-9-20 at 1:09 PM revealed the medication cart was not locked and all certified nurse aides and even the houskeeper could have access to medications in the cart. The cart contained buble packet medications for resident #909, #911, and #912. On 9-8-20 at 1:09 PM operator A confirmed the medication cart was unlocked and that certified nurse aides had access to the medication cart. Operator A failed to ensure only licensed nruses and medication aides had access to the stored medications and biologicals.	S3215		
S3220 SS=E	26-41-205 (k) Medication Clinical Record (k) Clinical record. The administrator or operator, or the designee, shall ensure that the clinical record of each resident for whom the facility manages medication or prefills medication containers or syringes contains the following documentation: (1) A medical care provider ' s order for each medication; (2) the name of the pharmacy provider of the resident ' s choice; (3) any known medication allergies; and (4) the date and the 12-hour or 24-hour clock time any medication is administered to the resident.	S3220		

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S3220	Continued From page 15 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(k)(1) The facility reported a census of 9 residents. The sample included 3 residents and 2 focused record reviews. Based on observation, record review, and interview the operator failed to ensure 3 resident's (#909, #911, #912) who the facility staff assisted with medications clinical record contained a medical provider's order for each medication. Findings included: - Review of resident #909's medical record revealed she admitted to the facility on 4-1-12 with diagnoses of cerebral degeneration, hypertension, unsteady gait, anxiety and vertigo. Review of the resident's functional capacity screen (FCS) dated 10-2-19 revealed the resident required supervision with management of medications and treatments. Review of the resident's negotiated service agreement/health care service plan (NSA/HCSP) dated 10-4-19 revealed the staff provided the resident medication reminders due to not taking them correctly and the medications are bubble packed from local pharmacy. Review of the resident's record included a medication list dated 7-1-20 that lacked a medical providers signature. The record lacked additional current orders for the resident's medications.	S3220		

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S3220	Continued From page 16 Observation of the unlocked medication cart on 9-8-20 at 1:09 PM included bubble packed medications for the resident. The unlocked medication cart was accessible to certified nurse aides. The medications included: Rosuvastatin calcium 10 mg (milligrams) every (q) PM Propranolol 60 mg q day at noon Docusate sodium 100 mg twice a day in AM and PM Fexofenadine HCL 180 mg q day in AM Diltazem 24 hr ER 180 mg q day at bedtime Multivitamin q day at noon Aspirin EC 81 mg q day in PM Montelukast Sodium 10 mg q day in PM Omeprazole 40 mg q day in AM Guanfacine 1 mg q day in AM Eszopiclone 1 mg q day at bedtime Calcium 600 mg + vitamin D twice a day in AM and PM - Review of resident #911's medical record revealed the resident admitted to the facility on 5-10-15 with diagnoses of debility related to cerebral anoxia. Review of the residents FCS dated 6-24-20 revealed the resident needed supervision with medication administration and could not administer medication treatments. Review of the resident's NSA/HCSP dated 6-24-20 revealed a local pharmacy bubble packed the resident's medications and the facility staff provided medication reminders. Review of the resident's record included a	S3220		

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S3220	Continued From page 17	S3220		

medication list dated 7-1-20 that lacked a medical providers signature. The record lacked additional current orders for the resident's medications.

Observation of the unlocked medication cart on 9-8-20 at 1:09 PM included strip packaging for the resident's medications. The unlocked medication cart was accessible to certified nurse aides. The medications included:
Levothyroxine 50 mcg at 6:00 AM
Aspirin ER 325 mg at 8:00 AM
Phenytoin 100 mg at 8:00 AM
Metformin 500 mg at 8:00 AM
Lisinopril 5 mg at 8:00 AM
Ferrous Sulfate 325 mg at 8:00 AM
Certavite senior 1 at 8:00 AM
Simvistatin 20 mg at 6:00 PM
Phenytoin 100 mg at 6:00 PM
Metoprolol 25 mg at 6:00 PM
Timolol 0.5% 1 drop in left eye every morning
Latanoprost 0,005% 1 drop in left eye every night

- Review of resident #912's medical record revealed she admitted to the facility on 4-11-18 with diagnoses of coronary artery disease, thyroid disease, hypertension and edema.

Review of the resident's FCS dated 6-24-20 revealed the resident required supervision with medication administration and physical assistance of management of medical treatments.

Review of the residents NSA/HCSP dated 6-24-20 revealed the resident's medications were bubble packed by local pharmacy and facility staff will do medication reminders.

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S3220	Continued From page 18 Review of the resident's record included a medication list dated 7-1-20 that lacked a medical providers signature. The record lacked additional current orders for the resident's medications. The list of medications did not include the Lisinopril 2.5 mg that was in the medication cart. Observation of the unlocked medication cart on 9-8-20 at 1:09 PM included strip packaging for the resident's medications. The unlocked medication cart was accessible to certified nurse aides. The medications included: Lisinopril 2.5 mg daily in AM Spironolactone 25 mg daily in AM Furosemide 80 mg daily in AM Fexofenadine HCL 180 mg daily in AM Magnesium oxide 400 mg daily in AM Carvedilol 6.25 mg twice daily AM and PM Temazepam 15 mg daily at bed time L-Thyroxine 50 mcg daily in the AM Omeprazole DR 20 MG twice daily Noon and bedtime Potassium CL ER 20 meq daily in AM Sertraline HCL 50 mg daily in AM Warfarin sodium 2.5 mg daily in PM During an interview on 9-9-20 at 10:51 AM after reviewing each resident record, Operator A confirmed resident #909, #911, and #912 the resident did not have current signed medical providers orders for each medication staff administered. The operator failed to ensure resident #909, #911, and #912's medications were administered in accordance with a medical care provider's written order and standards of practice. The	S3220		

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S3220	Continued From page 19 operator also failed to ensure that a licensed nurse or medication aide administer and managed the residents medications who required staff assistance with administration.	S3220		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (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 care home; 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 have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR-26-41-102 (d)(2)	S3248		

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S3248	Continued From page 20 The facility reported a census of 9 residents and sample included 3 residents with 2 focused reviews. Based on interview and record review, the operator failed to ensure 5 of 5 employee records contained supporting documentation of criminal background checks submitted upon hire through the appropriate agency. This had the potential to affect all residents in the facility. Findings included: - Review of employee files conducted on 3/29/18 at 11:00 AM revealed the following: Certified staff C hired on 7-25-19 and review of her record lacked evidence of a criminal background check completed upon hire through the required agency. Certified staff D hired on 9-16-19 and review of her record lacked evidence of a criminal background check completed upon hire through the required agency. Certified staff E hired on 8-18-20 and review of her record lacked evidence of a criminal background check completed upon hire through the required agency. Certified staff F hired on 8-24-20 and review of her record lacked evidence of a criminal background check completed upon hire through the required agency. Housekeeping staff G hired on 6-23-20 and review of her record lacked evidence of a criminal background check completed upon hire through the required agency. Operator A contacted human resources staff H who confirmed she did not go through the KDADS required criminal background agency for	S3248		

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S3248	Continued From page 21 newly hired staff. The operator failed to ensure employee records contained supporting documentation of criminal background checks submitted to the appropriate agency upon hire. This had the potential to affect all residents in the facility	S3248		
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 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 9 residents. Based on record review and interview the operator failed to ensure disaster and emergency preparedness by ensuring the performance of	S3280		

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S3280	Continued From page 22 quarterly review of the facility's emergency management plan with employees and residents. This failure had the potential to affect all residents in the facility. Findings included: - Review of the emergency management plan notebook with operator A revealed blank pages for the quarterly reviews. On 9-8-20 at 12:55 PM operator A confirmed the pages were blank and stated that she had not completed any quarterly reviews of the emergency management plan with residents and staff. The operator failed to ensure disaster and emergency preparedness by failing to complete quarterly reviews of the facility's emergency management plan with employees and residents.	S3280		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or	S3298		

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S3298	Continued From page 23	S3298		

friends for individual residents shall not be required to meet federal, state, and local laws and regulations.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-206(d)

The facility reported a census of 9 residents. Based on record review and interview the operator failed to ensure designated staff prepared foods using safe methods to ensure serving foods at the proper temperature. This failure had the potential to effect all residents.

Findings included:

- During initial tour on 9-8-20 record review of the food temperature log revealed the September food temperature log did not include a place for staff to monitor food temperatures of food served at breakfast. It also lacked documentation of food temperatures for lunch on 9-1,2-20 and supper on 9-3,4,6,7-20.

During an interview on 9-8-20 at 12:04 PM certified staff B reported all food is prepared at the new local hospital and then brought to the facility. Staff B confirmed the form did not have a place to monitor breakfast temperatures and that there were days when the temperatures were not taken.

During an interview on 9-9-20 at 12:30 PM operator A reported she picked up breakfast from the hospital on her way to work but did not realize staff needed to take the temperature of

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S3298	Continued From page 24 breakfast foods. Staff A also confirmed staff had failed to monitor temperature of foods for both lunch and supper on the dates listed above. The operator failed to ensure dietary staff monitor temperatures of food to ensure food safety and serving of food at the proper temperatures.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR26-41-206(e) The facility reported a census of 9 residents. Based on observation and interview the facility failed to store all food under safe and sanitary conditions. Findings included: - Observation on 9-9-20 at 8:15 AM of food items in the refrigerator revealed the following: A cottage container contained a red sauce but did not have a date or label A sour cream container had moldy scalloped potatoes without a date or label An ice cream container with lasagna but did not have a date or label.	S3299		

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S3299	Continued From page 25 A juice box that was opened without an open date The refrigerator also contained the following homemade food items: jar of sliced pickles, jar of cinnamon sticks, jar of apple butter, a jar of jalapeno jelly, a jar of sand plum jam, and 2 other jars of some type of jelly. All jars were opened and partially used. During an interview on 9-9-20 at 8:31 AM operator A stated all left overs are supposed to be thrown away the next morning and staff only put a date/label on it if it is going to be in the fridge for longer than a few hours. The operator failed to ensure staff stored all food under safe and sanitary conditions.	S3299		
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	S3310		

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S3310	Continued From page 26 by: K.A.R 26-41-207(c) The facility reported a census of 9 residents. The sample included 3 residents and 2 focused reviews, and review of 5 newly hired employee records. Based on interview and record review for 3 of 5 new employees the operator 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. This failure effected all residents who lived in the residential health care facility. Findings included: - Review of 3 of 5 newly hired employees file revealed the following: Certified staff E's record revealed she hired on 8-18-20 and the facility conducted a TB questionnaire on 8-13-20, but did not complete the 2 step TB skin testing. Certified staff F's record revealed she hired on 8-24-20 and had a TB questionnaire completed on 8-13-20 but did not receive the 2 step TB skin test.. Housekeeping staff G's record revealed she hired on 6-23-20 and had a previous TB skin test completed on 1-7-20 but did not have a TB questionnaire or TB skin test completed upon hire. During an interview on 9-9-20 at 9:32 AM Operator A reported she had not completed TB questionnaires with newly hired employees and thought they did not have to do the second TB	S3310		

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S3310	Continued From page 27 skin testing related to the previous serum shortage. For 3 of 5 newly hired employees, the operator 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		