STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046066	A. BUILDING: _____ B. WING _____	R-C 02/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACKHAWK ASSISTED LIVING	22550 S FRANKLIN STREET SPRING HILL, KS 66083

(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 at the above named assisted living facility conducted on 1-29,30-2020 & 2-3,4-2020.	{S 000}		
{S3085} SS=D	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) The facility reported a census of 34 residents. The sample included 3 residents and 6 focused record reviews. Based on interview and record review the operator failed to ensure designated staff developed a negotiated service agreement that included a description of the services the resident would receive for 1 (#1340) of 3 sampled residents.	{S3085}		

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

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{S3085}	Continued From page 1 Findings included: - Review of resident #1340's medical record revealed she admitted to the facility on 1-7-2020 with diagnoses of dysphasia, diabetes type 2, difficulty walking, and osteoporosis. Review of the resident's functional capacity screen dated 1-7-2020 revealed the resident required physical assistance with all activities of daily living, had bladder incontinence, impaired cognition, and had a current problem/risk for falls. Review of the negotiated service agreement dated 1-9-2020 revealed staff provided assistance with activities of daily living. It also identified that Hospice would provide a bolster mattress pad to prevent resident from rolling out of bed as well as highback wheelchair. The Negotiated service agreement lacked services related to staff placing pool noodle under the fitted sheet on the open side of the bed or the placement of a floor mat beside the bed when resident is in the bed. During an interview on 2-3-2020 at 12:52 PM licensed nursing staff B stated the pool noodles and fall mat were interventions that were adder after her fall and stated she type it up and add the broda chair along with the pool noodles and floor mat. The administrator failed to ensure designated staff developed a NSA for each resident that included a description of services the resident would receive.	{S3085}		

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{S3165}	Continued From page 2	{S3165}		
{S3165} SS=F	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility reported a census of 34 residents. The sample included 3 residents and 6 focused record reviews. Based on record review and interview for all resident's the operator failed to ensure the negotiated service agreement contained the name of the licensed nurse responsible for the implementation and supervision of the health service plan for all residents and for 3 (#1340, #1350, #1360) of 3 sampled residents. Findings included: - Review of resident #1340's medical record revealed the resident admitted to the facility on 1-7-2020 with diagnoses of Dementia and dysphasia. Review of the resident's functional capacity screen revealed the resident needed physical assistance with activities of daily living and could not manage her medications. Review of the negotiated service agreement dated 1-9-2020 had licensed nurse J's name crossed out and failed to include the name of the	{S3165}		

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{S3165}	Continued From page 3 person responsible for the implementation and supervision of the health care service plan. - Review of the resident #1350's medical record revealed the resident admitted to the facility on 11-7-2019 with diagnoses of hypertension and brain tumor. Review of the resident's functional capacity screen dated 12-26-2019 revealed the resident had bladder incontinence, was independent with activities of daily living, and needed supervision with management of medical treatments. Review of the residents negotiated service agreement included licensed nurse J as responsible for the implementation and supervision of the health care service plan. Licensed nurse J is not employed by the facility. - Review of resident #1360's medical record revealed the resident admitted to the facility on 3-19-2018 with diagnoses of diabetes type 2 and dementia. Review of the resident's functional capacity screen dated 1-16-2020 revealed the resident required physical assistance with bathing and toileting, the resident could not manage his own medications, had impaired cognition, and current problems with falls, inappropriate behaviors,and impaired decision making. Review of the resident's negotiated service agreement dated 1-16-20 included the name of licensed nurse J as responsible for the implementation and supervision of the health care service plan.. Licensed nurse J is not employed by the facility.	{S3165}		

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{S3165}	Continued From page 4 During an interview on 2-3-2020 at 12:43 PM licensed nursing staff B reported she typically just lined out the other nurses name and left "RCD" (resident care director) and does not put her name on the service agreement as being responsible for the health care service plan. The administrator failed to ensure the negotiated service agreement identified the licensed nurse responsible for implementation and supervision of the health service plan.	{S3165}		
{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 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: K.A.R 26-41-305(d)	{S3200}		

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{S3200}	Continued From page 5	{S3200}		

The facility reported a census of residents. The sample included 3 residents and 6 focused record reviews. Based on interview and record review the operator failed to ensure staff administered medications for 2 (#1340 and #1360) of 3 sampled residents in accordance with medical care provider orders and professional standards of practice.

Findings included:

- Review of resident #1340's medical record revealed she admitted into the facility on 1-7-2020 with diagnoses of dysphasia, difficulty walking, and diabetes type 2.

Review of the resident's functional capacity screen dated 1-7-2020 revealed the resident could not manage her medications or medical treatments.

Review of the resident's negotiated service agreement dated 1-9-2020 revealed that staff would manage and administer all medications.

Review of the January 2020 medication administration record revealed the resident received Citalopram (an antidepressant) 10 mg tablets daily starting 1-22-2020. It also revealed the resident received Oysco 500 mg daily starting 1-9-2020.

Review of the residents medical record lacked evidence of a physicians order for Citalopram or Oysco.

During an interview on 2-3-2020 at 10:40 AM licensed nursing staff B reported the resident received Hospice services and when the nurse wrote orders for any medication changes they

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{S3200}	Continued From page 6 were supposed to leave the new orders with Licensed nursing staff B. The operator failed to ensure staff followed standards of practice regarding to having a physicians order for all medications administered. - Review of resident #1360's medical record revealed the resident admitted to the facility on 3-19-2018 with diagnoses of diabetes type 2, major depression and Dementia. Review of the residents negotiated service agreement dated 1-28-2020 revealed staff would administer the resident's medications. Review of the January 2020 medication administration record revealed the resident received Gabapentin 100 mg. three times per day. Review of the residents medical record lacked evidence of a medical providers order for the Gabapentin. On 2-3-2020 at 11:35 AM licensed nursing staff B looked through the residents records and could not find a medical providers order for the Gabapentin. The operator failed to ensure staff administered the residents medications according to standards of practice regarding having a physicians order for all medications administered.	{S3200}		
{S3211} SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may	{S3211}		

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{S3211}	Continued From page 7 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 facility reported a census of 34 residents. Based on observations and interview for all residents, the operator failed to ensure all over-the-counter medications contained the full name of the resident on the medication package and the medication container. Findings included: - Observation of the medication room and medication carts on 1-30-2020 at 1:50 PM with certified staff F included the following observations: Medication cart #2 contained a bottle of daily fiber without a name on it and staff F stated the label came off and put one on the bottle that laid in the plastic box. It also included a bottle of aspirin 81 mg with a resident initials on it; a bottle of Vitamin D3 with a resident's last name on it.; A bottle of Acetaminophen 500mg with initials on it and an unopened bottle of low dose ASA with a	{S3211}		

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{S3211}	Continued From page 8 room number on it; A bottle of Pureform Omega naturals, HM-ET Binder - Kidney and Liver support and Artemisia Supreme without a residents name on them. It also included a box of Eliquis 5 mg tablets without a resident's name on the box. Observation in cart # 1 - observations revealed a bottle of prenatal nursing women supplement without a name or label and licensed nursing staff B said the label fell of f and took a label that lay in the plastic box where the bottle was and put it on the bottle. It also contained a bottle of Eye itch relief with a resident's last name only and a bottle of Victron iron plus C with no name on the bottle. During an interview on 2-3-2020 at 12:39 PM licensed nursing staff B confirmed all over the counter medications needed the resident's full name on the bottle/tube. The operator failed to ensure all over-the-counter medications contained the full name of the resident on the medication package and the medication container.	{S3211}		
{S3214} SS=D	26-41-205 (g) (4) Sample & Indigent Medication Program Meds (g) (4) Licensed nurses and medication aides may administer sample medications and medications from indigent medication programs if the administrator or operator ensures the development of policies and implementation of procedures for receiving and identifying sample medications and medications from indigent medication programs that include all of the following conditions: (A) The medication is not a controlled medication.	{S3214}		

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{S3214}	Continued From page 9 (B) A medical care provider ' s written order accompanies the medication, stating the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration. (C) A licensed nurse or medication aide receives the medication in its original, unbroken manufacturer ' s package. (D) A licensed nurse documents receipt of the medication by entering the resident ' s name and the medication name, strength, and quantity into a log. (E) A licensed nurse places identification information on the medication or package containing the medication that includes the medical care provider ' s name; the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider ' s order. Facility staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches the information on the medical care provider ' s order. (F) A licensed nurse informs the resident or the resident ' s legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies. The resident ' s clinical record shall contain documentation that the resident or the resident ' s legal representative has received the information and accepted the risk of potential adverse consequences.	{S3214}		

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{S3214}	Continued From page 10 This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(4)(B)(D)(E)(F) The facility reported a census of 34 residents. The sample included 3 residents, and 6 focused record reviews. Based on observation, interview and record review the operator failed to ensure 1 (#1290) of 1 resident who received sample medications included the following conditions: Operator ensured the development of policies and the implementation of procedures for receiving and identifying sample medications and medications from indigent medication programs that included all of the following conditions: (B) A medical care provider's written order accompanies the medication, stating the resident's name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration. (D) A licensed nurse documents receipt of the medication by entering the resident's name and the medication name, strength, and quantity into a log. (E) A licensed nurse places identification information on the medication or package containing the medication that includes the medical care provider's name; the resident's name, cautionary instructions as documented on the medical care providers order. (F) A licensed nurse informs the resident or the resident's legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A.65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies. The resident's clinical record shall contain documentation that the resident or the resident's legal representative has received	{S3214}		

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{S3214}	Continued From page 11 the information and accepted the risk of potential adverse consequences. Findings included: - Review of resident #1290's clinical record revealed he admitted to the facility on 10/16/19 with diagnoses of congestive heart failure and paroxysmal atrial fibrillation. Review of the resident's functional capacity screen dated 1-15-2020 revealed the resident needed physical assistance with medication and treatment and a cognitive score of 0 indicating no cognitive impairment. Review of the residents negotiated service agreement/health care service plan dated 1-15-2020 revealed staff would store, order, and administer the resident's medications. Review of the physician's order signed 1-16-2020 included an order for Apixaban (Eliquis) 5 mg tablet twice a day. Observation on 1-30-2020 at 1:50 PM observation of cart #2 with certified staff F revealed a box of Eliquis 5 mg tablets without a resident name or any other information on it. It lacked a resident name, medical care provider's name, dosage, route and frequency of administration and any cautionary instructions as documented on the medical care provider's order. The information also lacked any information to identify that 2 licensed nurses or a licensed nurse and medication aide verified the information on the medication matched the information on the medical care provider's order. On 1-30-2020 at 2:04 PM Operator staff A stated	{S3214}		

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{S3214}	Continued From page 12	{S3214}		

the facility had developed a policy for samples and then asked if the box needed a label on it.

Observation on 1-30-2020 at 2:10 PM surveyor looked in the cabinets where resident overflow is kept, and the resident had no other boxes of Eliquis and no log noted for receiving the medications.

On 1-30-2020 at 2:11 PM Licensed nursing staff B stated the facility did not have a log that documented receiving the medications and did not have evidence of notification to the family that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A 65-1642.

During an interview on 2-3-2020 at 8:37 AM certified staff C stated the resident had brought in more samples of Eliquis and she had them in the med room over the weekend and put them on licensed nurse B's desk today for her to check them and put the information on the box.

Review of the sample medication policy dated 7-15-2018 revealed a licensed nurse would document receipt of the medication by entering the resident's name and the medication name, strength, and quantity in a log. A licensed nurse places identification information on the medication or package that included medical care provider's name; the resident's name, medication name, strength, dosage, route, and frequency of administration, and any cautionary measures as documented on the physicians order. Either 2 nurses or a nurse and CMA will verify the information on the medication matches the information on the physicians order. It also included a nurse would inform resident or legal representative the medication did not go through

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{S3214}	Continued From page 13 the usual process of labeling and a review by a pharmacist which would identify drug interactions and/or reactions and potential allergies. The record shall contain documentation that the resident or legal representative received the above information and accept the risk of potential adverse consequences. The operator failed to ensure the implementation of procedures for receiving sample medications including all the appropriate information regarding the administration of sample medications for resident #1290 was written and explained to the resident or his/her legal representative, failed to include appropriate information on the medication box, and failed to have the appropriate information regarding the acceptance of the medication in the facility.	{S3214}		
{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 14 (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 34 residents. Based on observation and interview the operator failed to ensure designated staff stored medications, including insulin pens according to standards of practice and manufacturer recommendations. Findings included: - During initial tour of the medication room and medication carts on 1-29-2020 at 1:50 PM with certified staff F revealed the following: Cart # 2 had 3 insulin pens - 2 Lantus pens had resident names but did not have a date when the pen was opened. One of the pens had approximately 40 units left and the other pen had approximately 160 units left. During an interview on 1-29-2020 at 1:52 PM	{S3215}		

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	N046066	A. BUILDING: _____ B. WING _____	R-C 02/04/2020

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{S3215}	Continued From page 15 certified staff F said staff were supposed to put the date on it when they open it. staff A reported all of the medications should have had the residents name on them and insulin needed a date when opened. During an interview on 2-3-2020 at 12:56 PM licensed nursing staff B reported staff needed to write the date on the pen when it was opened. Review of the manufacture recommendation for storage revealed opened pens are to be stored at room temperature for 28 days and then discarded. The operator failed to ensure all medications were stored according to standards of practice and manufacturer recommendations.	{S3215}		
{S3290} SS=E	26-41-206 (a) (b) Dietary Services (a) Provision of dietary services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. If the administrator or operator of the facility establishes a contract with another entity to provide or coordinate the provision of dietary services to the residents, the administrator or operator shall ensure that entity ' s compliance with these regulations. (b) Staff. The supervisory responsibility for dietetic services shall be assigned to one employee. (1) A dietetic services supervisor or licensed dietician shall provide scheduled on-site supervision in each facility with 11 or more	{S3290}		

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{S3290}	Continued From page 16	{S3290}		

residents.
(2) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian.

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

The facility reported a census of 34 residents. The sample included 3 residents and 6 focused record review. Based on observation, interview and record review the operator failed to ensure staff provided 3 (#1310, #1320, and #1330) of 3 residents with a therapeutic diet as ordered by their medical provider.

Findings included:

- During initial tour of the kitchen revealed a board with resident multiple residents pictures and diet order written on the picture and identified as needing to be served a therapeutic diet.

During an interview on 1-30-2020 at 7:21 AM dietary staff I reported the pictures of the resident on the board are the ones who have special diets. Staff I stated residents who had a mechanically soft diet basically we just grind it up. Staff I stated they did not have any specific instruction to look at to identify how to prepare the therapeutic diets.

- Review of resident #1310's medical record

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{S3290}	Continued From page 17	{S3290}		

revealed he admitted to the facility on 3-2-2016 with diagnosis of diabetes type 2.

Review of the residents functional capacity screen dated 10-16-2019 identified the resident was independent with eating and had a cognitive score of 4 indicating cognitive impairment.

Review of the negotiated service agreement dated 10-8-2018 noted the resident had a regular diet with hand written addition dated 11-15-2018 for the resident to receive nectar thick liquids.

Review of the residents current NSA dated 1-30-2020 but is unsigned identified the resident refused thickened liquids at times.

Review of the signed but undated physicians orders included a diet order for nectar thick liquids.

Observation on 1-30-2020 at 7:44 AM the resident had been sitting at the dining room table and coughed a few times while drinking fluids. Observation of the resident's liquids revealed the resident had a glass of water, tomato juice and orange juice and a cup of coffee and each one appeared to be regular thin liquids.

On 1-30-2020 at 12:58 PM dietary staff E reported the resident refused to drink the nectar thickened liquids so family said just to add a little to it and then he will drink it.

On 1-30-2020 at 12:23 PM licensed nursing staff B stated she had not completed any refusal of services for the resident.

The operator failed to ensure staff served resident #1310 nectar thickened liquids as

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{S3290}	Continued From page 18 ordered by the medical provider. - Review of resident #1320's medical record revealed the resident admitted to the facility on 8-9-19 with diagnoses of dementia, diabetes type 2, and dysphasia, pharyngoesophageal phase. . Review of the residents functional capacity screen dated 12-30-2019 revealed the resident was independent with eating and had some cognitive impairment. Review of the residents negotiated service agreement dated 1-10-2020 revealed the resident did not require assistance with meals. It identified the resident required a mechanical soft diet but is noncompliant with it. Physician and family aware. Review of the resident's medical record included a medical care providers order dated 8-14-2019 for regular diet mechanical soft texture with thin liquids. Observation on 1-30-2020 at 7:59 resident had finished eating a bowl of oatmeal - at 8:03 AM the resident was served biscuits and gravy - 2 slices of bacon and 2 fried eggs. On 1-30-2020 at 12:23 PM licensed nursing staff B stated she had not completed a refusal of services for the resident. During an interview on 1-30-2020 at 12:57 PM operator staff A reported the resident had been refusing to eat the mechanical diet/pureed diet and it should say that in their negotiated service agreement - Review of resident #1330's medical record revealed the resident admitted to the facility on	{S3290}		

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{S3290}	Continued From page 19 8-20-2013 with diagnoses of Alzheimer's disease, and functional dysphasia. Review of the residents functional capacity screen dated 6-27-19 revealed the resident was independent with eating and had cognitive impairment. Review of the residents negotiated service agreement dated 6-11-19 revealed a regular diet with soft foods - observe for pocketing. Review of the resident record included a medical providers order for mechanical soft solids. Review of the "current" unsigned negotiated service agreement dated 1-8-2020 that identified the resident had a mechanical soft diet, thin liquids order and is non-compliant with order, medical provider notified. Review of the medical providers order dated 5-14-2019 included a diet order for mechanical soft, with thin liquids. Observation on 1-30-2020 at 7:57 AM the resident sat at the dining room table eating oatmeal. At 8:05 AM staff served the resident biscuits and gravy, scrambled eggs and sausage links cutup into about ½ inch pieces. Observation of the resident's plate when she was done eating revealed the resident left most of her sausage uneaten. On 1-30-2020 at 12:23 PM licensed nursing staff B stated she had not completed a refusal of services for the resident. During an interview on 1-30-2020 at 12:57 PM operator staff A reported the resident had been refusing to eat the mechanical diet/pureed diet	{S3290}		

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{S3290}	Continued From page 20 and it should say that in their negotiated service agreement. The operator failed to ensure dietary staff had instructions on how to provide a mechanically soft diet and staff failed to provided therapeutic diets for 3 residents as ordered by their medical provider.	{S3290}		
{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 by: K.A.R 26-41-207(c) The facility reported a census of 34 residents. The sample included 3 residents and 6 focused record reviews. Based on interview and record review for 2 of 2 new employee records, the operator failed to ensure the facility remained in compliance with the department's tuberculosis	{S3310}		

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{S3310}	Continued From page 21 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 2 newly hired employees file revealed the following: Certified staff G hired onto the facility on 1-8-2020 and had not received her TB questionnaire or her TB skin test as of 1-29-2020. Certified staff H hired onto the facility on 12-31-2019 and had not received her TB skin testing or the TB questionnaire completed. During an interview on 1-29-2020 at 3:30 PM operator A reported the 2 new hires have not had their TB questionnaire done or their TB skin tests done. For 2 of 2 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}		