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 _____	C 12/12/2019

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 with complaints (#147669, #147626, #146930, #143067, #134925, #134769, #131664, #130476) at the above named assisted living facility conducted on 12-9-19, 12-10-19, 12-11-19, and 12-12-19.	S 000		
S3026 SS=D	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(A) The facility reported a census of 34 residents. The sample included 3 residents and 3 focused reviews. Based on interview, and record review for 1 (#136) of 3 focused record reviews revealed the operator failed to ensure the resident was not subjected to verbal or physical abuse when dietary staff F and resident #136 had a verbal/physical encounter which resulted in the resident falling to the floor. Findings included: - The resident admitted to the facility on 3-19-18 with diagnoses of parkinsons, diabetes type 2,	S3026		

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
	N046066	A. BUILDING: _____ B. WING _____	C 12/12/2019

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
S3026	Continued From page 1 depression and hypertension. Review of the resident's functional capacity screen dated 6-27-19 revealed the resident needed physical assistance with bathing and toileting, supervision with dressing and was independent with transfers, walking and eating. It identified the resident had cognitive deficit but could understand what others said and make himself understood. It revealed the resident had current/recent problems with falls, impaired hearing, socially inappropriate disruptive behavior and impaired decision making. Review of the resident's negotiated service agreement dated 6-10-19 identified the resident had increased anxiety at times and staff needed to provide reassurance and staff managed all of the residents medications. Review of the resident's nurse's notes dated 11-12-19 revealed the resident came to the dining room for breakfast and at approximately 8:44 AM the resident went to get a cup of coffee in the kitchen area and dietary staff F told the resident he could not be in the kitchen. Resident #136 and dietary staff F then got into a verbal confrontation and when the staff tried to get the resident out of the kitchen the resident fell to the floor and denied any injuries. Review of the facility's investigation of the incident revealed the resident made derogatory statements to the dietary staff F who in turn told the resident to get out of the kitchen. The resident was at the kitchen door and staff F went to the resident and they were close to each other and looked like they were pushing against each other. The resident ended up falling to the ground and did not have any injuries.	S3026		

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 _____	C 12/12/2019

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
S3026	Continued From page 2 During an interview on 12-11-19 at 11:30 the resident stated things were going OK at the facility. When asked specifically about the incident with the dietary staff F the resident said "The guy in the kitchen was wrong." The resident said he was on his side by the coffee machine and was OK for him to be there. He stated dietary staff F kicked him and he fell backwards. During an interview on 12-11-19 at 12:20 PM licensed nursing staff J reported there is red tap on the floor in the kitchen where resident's are not supposed to pass. Staff J reported based on her investigation the resident was by the coffee pots and it was OK for the resident to be there. Staff J stated based on her investigation the incident occurred and dietary staff F was suspended immediately and then terminated based on the investigation and substantiation of abuse. Requested policies on 12-12-19 for abuse, neglect, and exploitation and the operator did not provide one. The operator failed to ensure resident #136 remained free from subjection to verbal and physical abuse.	S3026		
S3050 SS=F	26-41-101 (k) Ombudsman (k) Ombudsman. Each administrator or operator shall ensure the posting of the names, addresses, and telephone numbers of the Kansas department on aging and the office of the long-term care ombudsman with information that these agencies can be contacted to report actual or potential abuse, neglect, or exploitation of	S3050		

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 _____	C 12/12/2019

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
S3050	Continued From page 3 residents or to register complaints concerning the operation of the facility. The administrator or operator shall ensure that this information is posted in an area readily accessible to all residents and the public. This REQUIREMENT is not met as evidenced by: K.A.R 26-41-101(k) The facility reported a census of 34 residents. Based on observations and interview the facility failed to have a posted notice of the names, addresses, and telephone numbers of the Kansas department for aging and disabilities (KDADS) and with information that this agencies could be contacted to report actual or potential abuse, neglect or exploitation of residents or to register complaints concerning operation of the facility. This affected all 3 residents. Findings Included: - During tour of the facility on 12-9-19 revealed the facility lacked a posting of the Kansas Department for Aging and Disabilities)KDADS) information directing residents, families and staff on how they could report potential abuse or complaints concerning the operation of the facility. During an interview on 12-9-19 at 3:14 PM operator staff A reported she did not realize the KDADS information was not posted for residents and the public to see. During the survey from 12-9-19 to 12-11-19 the facility continued to lack a posting of the KDADS	S3050		

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 _____	C 12/12/2019

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
S3050	Continued From page 4 information. The facility failed to ensure information for KDADS and how to contact them was posted in a readily accessible area for residents and the public.	S3050		
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) The facility reported a census of 34 residents. The sample included 3 residents and 3 focused record reviews. Based on interview and record review the operator failed to ensure designated staff developed a negotiated service agreement	S3085		

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 _____	C 12/12/2019

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
S3085	Continued From page 5	S3085		

that included a description of the services the resident would receive and identification of the provider of each service for 4 (#130, #131, #134 and #136) of 6 residents records reviewed.

Findings included:

- Review of resident #130's medical record revealed she admitted to the facility on 1/10/15 with diagnoses of Alzheimer, anxiety, and constipation.

Review of the residents functional capacity screen dated 12-9-19 revealed the resident required physical assistance with all activities of daily living except eating. The resident also had bladder incontinence, cognitive impairment and difficulties with communication. The resident was not able to manage her own medications and medical treatments and had recent/current problems with vision, hearing and impaired decision making.

Review of the resident's negotiated service agreement dated 2-8-18 revealed the facility staff will manage the resident's medications and medical treatments. Staff also provided physical assistance of 1 staff with all activities of daily living and supervised with eating. Staff provided reminders and prompting related to poor cognition.

The negotiated service agreement failed to include the intervention of using wheelchair only for transportation and if resident sitting and rocking in wheelchair to move her to a safer position.

- Review of resident #131's medical record

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 _____	C 12/12/2019

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
S3085	Continued From page 6	S3085		

revealed he admitted to the a facility on 12-9-18 with diagnoses of gout, hypertension Dementia and diabetes.

Review of the resident's functional capacity screen dated 11-19-19 revealed the resident needed physical assistance with management of medications and medical treatments. The resident also needed physical assistance with bathing, dressing, and toileting and had cognitive impairment with recent problems with falls.

Review of the resident's negotiated service agreement dated 6-3-19 revealed the facility would manage all of the resident's medications.

The negotiated service agreement failed to identify the resident received insulin and the certified medication aide would dial the insulin pen to the correct dose and hand it to the resident for self-injection.

- Review of resident #134's medical record revealed she admitted to the facility on 8-6-19 with diagnoses of diabetes type 2, mild cognitive dysfunction, hypertension, depression and anxiety.

Review of the resident's functional capacity screen dated 9-21-19 revealed the resident could not manage her own medications and medical treatments. The resident required physical assistance with bathing and dressing and was independent with transfers and walking. The resident also had recent/current problems with falls, wandering, inappropriate behaviors and impaired decision making.

Review of the resident's negotiated service

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 _____	C 12/12/2019

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
S3085	Continued From page 7	S3085		

agreement (NCSA) dated 8-7-19 revealed the community staff to manage the residents medications and blood sugar monitoring as ordered. It revealed family assisted with bathing and the staff provided assistance with dressing. The NSA directed staff to provide redirection and reassurance and that the resident used a walker related to fall risk.

The NSA failed to identify what staff needed to do for wandering or inappropriate behavior of disrobing. It also failed to identify the resident received insulin and the certified medication aide would dial the pen to the correct dosage and then had the pen to the resident for self injection.

- Review of resident #136's medical record revealed he resident admitted to the facility on 3-19-18 with diagnoses of parkinsons, diabetes type 2, depression and hypertension.

Review of the resident's functional capacity screen dated 6-27-19 revealed the resident needed physical assistance with bathing and toileting, supervision with dressing and was independent with transfers, walking and eating. The resident could not manage his own medications or medical treatments. It identified the resident had cognitive deficit but could understand what others said and make himself understood. It revealed the resident had current/recent problems with falls, impaired hearing, socially inappropriate disruptive behavior and impaired decision making.

Review of the resident's negotiated service agreement dated 6-10-19 identified the resident had increased anxiety at times and staff needed to provide reassurance and staff managed all of

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 _____	C 12/12/2019

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
S3085	Continued From page 8 the residents medications. It identified facility staff would administer all medications. The negotiated service agreement failed to identify the certified medication aide would dial the resident's pen to the correct dose and then hand to the resident for self-injection. During an interview on 12-11-19 at 11:48 AM licensed nursing staff B reported the negotiated service agreements needed to include all services the resident received. Requested policies on 12-12-19 for completion of the negotiated service agreement and the operator did not provide one. The administrator failed to ensure designated staff developed a NSA for each resident that included a description of services the resident would receive and identification of the provider of each service.	S3085		
S3090 SS=E	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: K.A.R 26-41-202(c) The facility reported a census of 34 residents. The sample included 3 residents and 3 focused	S3090		

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 _____	C 12/12/2019

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
S3090	Continued From page 9	S3090		

record reviews. . Based on record review the operator failed to ensure designated staff developed an initial negotiated service agreement at admission for 2 (#131 and #134) of 3 sampled residents.

Findings included:

- Review of resident #131's medical record revealed he admitted to the a facility on 12-9-18 with diagnoses of gout, hypertension Dementia and diabetes.

Review of the resident's functional capacity screen dated 11-19-19 revealed the resident needed physical assistance with management of medications and medical treatments. The resident also needed physical assistance with bathing, dressing, and toileting and had cognitive impairment with recent problems with falls.

Review of the resident's admission negotiated service agreement dated 12-10-18 the day after admission to the facility.

- Review of resident #134's medical record revealed she admitted to the facility on 8-6-19 with diagnoses of diabetes type 2, mild cognitive dysfunction, hypertension, depression and anxiety.

Review of the resident's functional capacity screen dated 9-21-19 revealed the resident could not manage her own medications and medical treatments. The resident required physical assistance with bathing and dressing and was independent with transfers and walking. The resident also had recent/current problems with falls, wandering, inappropriate behaviors and

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 _____	C 12/12/2019

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
S3090	Continued From page 10 impaired decision making. Review of the resident's admission negotiated service agreement (NCSA) dated 8-7-19 revealed it was completed the day after admission to the facility. During an interview on 12-11-19 at 11:46 AM licensed nursing staff B stated negotiated service agreement needed to be completed upon day of admission. Requested policies on 12-12-19 for completion of the negotiated service agreement and the operator did not provide one. The operator failed to ensure designated staff completed the a negotiated service agreement upon admission for 2 of 3 sampled residents.	S3090		
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 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.	S3092		

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 _____	C 12/12/2019

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
S3092	Continued From page 11 This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (d) (1) The facility reported a census of 34 residents. The sample included 3 residents and 3 focused reviews. Based on interview and record review the operator failed to ensure staff reviewed/revised 1 (#130) of 3 sampled residents Negotiated Service Agreement (NSA) at least once every 365 days. Findings Included: - Review of resident #130's medical record revealed she admitted to the facility on 1/10/15 with diagnoses of alzheimers, anxiety, and constipation. Review of the residents functional capacity screen dated 12-9-19 revealed the resident required physical assistance with all activities of daily living except eating. The resident also had bladder incontinence, cognitive impairment and difficulties with communication. The resident was not able to manage her own medications and medical treatments and had recent/current problems with vision, hearing and impaired decision making. Review of the resident's most recent/current negotiated service agreement staff completed on 2-8-18. The facility staff failed to review/revise the resident's negotiated service agreement at least once every 365 days. During an interview on 12-11-19 at 11:46 AM licensed nursing staff B reported the negotiated service needed to be completed on admission,	S3092		

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 _____	C 12/12/2019

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
S3092	Continued From page 12 with a significant change in condintion and every 6 months. The operator failed to ensure staff reviewed/revised the resident's negotiated service agreement at least once every 365 days.	S3092		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204 (a) The facility reported a census of 10 residents. The sample included 3 residents and 1 focused review. Based on interview and record review the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of 3 (#100, #200, and #300) of 3 residents, 1 of whom experienced a fall with a fracture. Findings included: - Review of resident #130's medical record revealed she admitted to the facility on 1/10/15 with diagnoses of Alzheimers, anxiety, and	S3155		

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 _____	C 12/12/2019

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
S3155	Continued From page 13	S3155		

constipation.

Review of the residents functional capacity screen dated 12-9-19 revealed the resident required physical assistance with all activities of daily living except eating. The resident also had bladder incontinence, cognitive impairment and difficulties with communication. The resident was not able to manage her own medications and medical treatments and had recent/current problems with vision, hearing and impaired decision making.

Review of the resident's negotiated service agreement dated 2-8-18 revealed the facility staff will manage the resident's medications and medical treatments. Staff also provided physical assistance of 1 staff with all activities of daily living and supervised with eating. Staff provided reminders and prompting related to poor cognition. The negotiated service agreement failed to include the intervention of using wheelchair only for transportation and if resident sitting and rocking in wheelchair to move her to a safer position.

Review of the resident's nurses noted revealed the resident had falls on the following dated: 8-21-18 slid out of wheelchair with no injuries; 12-9-18 fall out of bed with complaints of head pain; 8-19-19 fall out of wheelchair with bruising to left forehead; 9-11-19 fall our of wheelchair with hematoma to forehead, fall on 10-3-19 without injuries.

Surveyor requested facility investigations of falls to identify possible causal factors and identify any interventions to potentially reduce future falls.

On 12-11-19, Operator A provided investigations

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 _____	C 12/12/2019

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
S3155	Continued From page 14	S3155		

for falls on 8-20-19 and 9-11-19 but did not have investigations for the other falls to identify potential cause and identify interventions to reduce potential for future falls.

- Review of resident #131's medical record revealed he admitted to the a facility on 12-9-18 with diagnoses of gout, hypertension Dementia and diabetes.

Review of the resident's functional capacity screen dated 11-19-19 revealed the resident needed physical assistance with management of medications and medical treatments. The resident also needed physical assistance with bathing, dressing, and toileting and had cognitive impairment with recent problems with falls.

Review of the resident's negotiated service agreement dated 6-3-19 revealed the facility would manage all of the resident's medications. Staff also provided assistance of 1 with bathing, dressing, and toileting and provided reminders and cues related to cognition. It directed staff to remind the resident to use his walker for walking assistance.

Review of the resident's nurses notes revealed the resident had falls on the following dates: On 3-2-19 fell while trying to sit in chair; on 6-5-19 slid out of bed during the night with an intervention for frequent visual checks and to keep walker in reach; on 8-9-19 fall out of bed with laceration to right eyebrow with intervention to secure mattress to bed.

Surveyor requested facility investigations of falls to identify possible causal factors and identify any interventions to potentially reduce future falls.

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 _____	C 12/12/2019

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
S3155	Continued From page 15 On 12-11-19 Operator A provided investigation for falls on 6-5-19 and 8-9-19 but had no investigation for the fall on 3-2-19. - Review of resident #134's medical record revealed she admitted to the facility on 8-6-19 with diagnoses of diabetes type 2, mild cognitive dysfunction, hypertension, depression and anxiety. Review of the resident's functional capacity screen dated 9-21-19 revealed the resident could not manage her own medications and medical treatments. The resident required physical assistance with bathing and dressing and was independent with transfers and walking. The resident also had recent/current problems with falls, wandering, inappropriate behaviors and impaired decision making. Review of the resident's negotiated service agreement (NSA) dated 8-7-19 revealed the community staff to manage the residents medications and blood sugar monitoring as ordered. It revealed family assisted with bathing and the staff provided assistance with dressing. The NSA directed staff to provide redirection and reassurance and that the resident used a walker related to fall risk. It failed to identify what staff needed to do for wandering or inappropriate behavior of disrobing. Review of the resident's nurses notes revealed the resident had the following falls: On 8-14-19 fall in closet at 11:20 PM without injuries; On 8-24-19 resident on floor beside her bed. without injuries; on 8-29-19 fall in bathroom with sore hip; On 9-6-19 had a fall in the hall way, no injuries noted; On 11-6-19 had a fall the night of 11-5-19 when tripped on shoes and fell	S3155		

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 _____	C 12/12/2019

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
S3155	Continued From page 16 forward resulting in broken eye glasses and a hematoma over her left eye; and a fall on 12-1-19 the resident said she fell out of bed with a small cut to left forehead. Requested facility investigations of falls and operator failed to provide investigations for each fall which identified possible causal factors and potential interventions to reduce risk of future falls. During an interview on 12-11-19 at 11:41 AM licensed nursing staff B reported all falls should be investigated with an intervention put in place to prevent further falls based on what caused the resident to fall. Requested policies on 12-12-19 for falls and the operator did not provide one. For all 3 residents the administrator failed to ensure a licensed nurse provided or coordinated the necessary health care services to reduce falls by the failure to thoroughly investigate the root cause of the falls and implement measures to reduce the risk for further falls.	S3155		
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:	S3165		

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 _____	C 12/12/2019

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
S3165	Continued From page 17 KAR 26-41-204(d) The facility reported a census of 34 residents. The sample included 3 residents and 3 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 (#130, #131, and #134) of 3 residents. Findings included: - Review of resident #130's medical record revealed she admitted to the facility on 1/10/15 with diagnoses of Alzheimers, anxiety, and constipation. Review of the residents functional capacity screen dated 12-9-19 revealed the resident required physical assistance with all activities of daily living except eating. The resident also had bladder incontinence, cognitive impairment and difficulties with communication. The resident could not manage her own medications and medical treatments and had recent/current problems with vision, hearing and impaired decision making. Review of the resident's current negotiated service agreement dated 2-8-18 revealed failed to have an addendum with the current nurse responsible for implementation and supervision of the health service plan. - Review of resident #131's medical record revealed he admitted to the a facility on 12-9-18	S3165		

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 _____	C 12/12/2019

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
S3165	Continued From page 18 with diagnoses of gout, hypertension Dementia and diabetes. Review of the resident's functional capacity screen dated 11-19-19 revealed the resident needed physical assistance with management of medications and medical treatments. The resident also needed physical assistance with bathing, dressing, and toileting and had cognitive impairment with recent problems with falls. Review of the resident's negotiated service agreement dated 6-3-19 failed to include and addendum with the current nurse responsible for the implementation and supervision of the health service plan. - Review of resident #134's medical record revealed she admitted to the facility on 8-6-19 with diagnoses of diabetes type 2, mild cognitive dysfunction, hypertension, depression and anxiety. Review of the resident's functional capacity screen dated 9-21-19 revealed the resident could not manage her own medications and medical treatments. The resident required physical assistance with bathing and dressing and was independent with transfers and walking. The resident also had recent/current problems with falls, wandering, inappropriate behaviors and impaired decision making. Review of the resident's negotiated service agreement (NSA) dated 8-7-19 lacked an addendum with the current nurse responsible for the implementation and supervision of the resident's health service plan.	S3165		

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 _____	C 12/12/2019

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
S3165	Continued From page 19 During an interview for all residents on 12-12-19 at 1:48 PM licensed nursing staff B reported she had only done 1 resident's negotiated service agreement and that was yesterday for a new admission. Staff B stated she had not done any addendums for all other residents to identify her as the nurse responsible for implementation and supervision of the health 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		
S3166 SS=E	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR-26-41-204 (e) The facility reported a census of 34 residents. Based on interview and record review of 3 newly hired certified medication aides the operator failed to ensure the delegation of the nursing procedure of blood sugar monitoring to each certified medication aide under the Kansas nurse practice act, K.S.A.65-1124 and amendments thereto. This had the potential to effect all residents who had their blood sugar checked by	S3166		

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 _____	C 12/12/2019

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
S3166	Continued From page 20 certified medication aides. Findings included: - Review of employee records revealed certified staff C, G, and H did not have evidence of licensed nurse delegation for blood glucose testing which is not part of the certified medication aide curriculum. During an interview on 12-9-19 at 2:47 PM operator A reported the certified medication aides checked the resident's blood sugars. During an interview on 12-11-19 at 9:15 AM operator A reported she did not have any record of delegation for medication aides related to blood sugar monitoring. Requested policy regarding delegation for certified medication aides on 12-12-19 at 7:32 AM and was not provided. The operator failed to ensure the delegation of the nursing procedure of blood sugar monitoring to each certified medication aide under the Kansas nurse practice act, K.S.A.65-1124 and amendments thereto. The failure had the potential to effect all residents who had blood sugar checks monitored by certified medication aides.	S3166		
S3175 SS=E	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a	S3175		

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 _____	C 12/12/2019

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
S3175	Continued From page 21 licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 205(a) The facility identified a census of 34 residents. The sample included 3 residents and 3 focused record reviews. Based on record review, interview, and observation for 2 (#131 and #136) of 3 residents sampled who self injected their insulin, the operator failed to ensure staff perform an assessment and determine each resident could safely and accurately self-inject insulin after staff dialed the insulin pen before resident initially begins self-injection of insulin. Findings included: - Review of resident #131's medical record revealed he admitted to the a facility on 12-9-18 with diagnoses of gout, hypertension Dementia and diabetes. Review of the resident's functional capacity screen dated 11-19-19 revealed the resident	S3175		

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 _____	C 12/12/2019

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
S3175	Continued From page 22	S3175		

needed physical assistance with management of medications and medical treatments and the resident had cognitive impairment.

Review of the resident's negotiated service agreement dated 6-3-19 revealed the facility would manage all of the resident's medications. The negotiated service agreement failed to identify the resident received insulin and the certified medication aide would dial the insulin pen to the correct dose and hand it to the resident for self-injection.

Observation on 12-10-19 at 4:50 PM operator A got the resident's Humalog pen out of the medication cart, rolled the pen in her hands, put on the needle then dialed the pen to 37 units. Staff then went into the resident room and handed him the alcohol pad and she had take hold of his wrist and help him wipe an area on his abdomen. Staff A then handed the resident his insulin pen and he didn't know what to do so staff put her hand on his wrist and moved/guided it on his abdomen and told him to poke himself. The resident looked at staff A a couple of times and she had to repeat the instruction. With her had still on his wrist the resident poked his skin and then staff A told him to push it down and he pushed the plunger.

Observation on 12-11-19 at 7:53 AM certified staff C got the humalog pen and dialed it to 43 units. Staff went into the resident's room, handed him the pen and held onto his hand while he went to put in the pen. Staff C's had remained on top of his and as staff told the resident to push it in and the top of his hand's skin blanched where she had her hand.

Review of the residents record lacked an

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 _____	C 12/12/2019

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
S3175	Continued From page 23	S3175		

assessment of the resident's ability to self inject insulin after staff dialed the pen to the ordered dose.

- Review of the resident's record revealed he admitted to the facility on 3-19-18 with diagnoses of diabetes type 2.

Review of the resident's functional capacity screen dated 6-27-19 revealed the resident could not manage his own medications or medical treatments. It identified the resident had cognitive deficit but could understand what others said and make himself understood.

Review of the resident's negotiated service agreement dated 6-10-19 identified the staff would administer all medications. IT did not identify the staff dialed the insulin pen to ordered dose and the resident self injected the resident's insulin.

Observation on 12-10-19 at 8:55 AM certified staff C went to give the resident his insulin. Staff dialed the pen to 17 units and then handed the resident the pen. The resident was a little shaky but could self inject without staff assistance. During observation certified staff C stated the resident isn't as shaky so I didn't need to help him today.

The resident's record lacked an assessment to ensure the resident could safely inject his insulin after the certified aide dialed it to the ordered dose.

During an interview 12-11-19 at 11:59 AM licensed nursing staff J reported there should be a self med administration assessment with

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 _____	C 12/12/2019

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
S3175	Continued From page 24 identifying the resident could self inject the insulin. Requested policies on 12-12-19 for delegation and staff assistance with insulin pens and the operator did not provide one. The operator failed to ensure staff performed an assessment and determine each resident could safely and accurately self-inject insulin after staff dialed the insulin pen before resident initially begins self-injection of insulin.	S3175		
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		

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 _____	C 12/12/2019

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
S3200	Continued From page 25 The facility reported a census of residents. The sample included 3 residents and 3 focused record reviews. Based on interview and record review the operator failed to ensure staff administered medications for 3 (#130, #131, #134) of 3 sampled residents in accordance with medical care provider orders and professional standards of practice. Findings included: - Review of resident #130's medical record revealed she admitted to the facility on 1/10/15 with diagnoses of Alzheimers, anxiety, and constipation. Review of the residents functional capacity screen dated 12-9-19 revealed the resident was not able to manage her own medications and medical treatments. Review of the resident's negotiated service agreement dated 2-8-18 revealed the facility staff will manage the resident's medications and medical treatments. Review of a physicians communication dated 7-16-19 included an order for Zaditor eye drops, 1 drop both eyes twice a day for itchy, red eyes. Review of the medical care providers order sheet signed 11-25-19 included an order for Senna-S tablet, 1 twice a day for constipation. Review of the December 2019 medication administration record (MAR) also lacked evidence of staff administering the Zaditor eye drops to the resident. The MAR revealed the staff did not administer the Senna-s 11 times out	S3200		

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 _____	C 12/12/2019

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
S3200	Continued From page 26 of 17 due to medications not available, waiting pharmacy delivery. During an interview on 12-11-19 at 11:52 AM licensed nursing staff B reported when medications are not available the medication aide is to call the pharmacy to see what is going on and try to get it in the facility that day. They also need to call the nurse and let her know. During an interview on 12-10-19 at 4:21 PM licensed nursing staff B reported the order came from a Hospice nurse and did not get started. The operator failed to ensure staff followed standards of practice regarding administering medications according to physicians orders. - Review of resident #131's medical record revealed he admitted to the a facility on 12-9-18 with diagnoses of gout, hypertension Dementia and diabetes. Review of the resident's functional capacity screen dated 11-19-19 revealed the resident needed physical assistance with management of medications and medical treatments. Review of the resident's negotiated service agreement dated 6-3-19 revealed the facility would manage all of the resident's medications. Review of the December 2019 medication administration record (MAR) included a medical care providers order for Humulin N insulin, inject 25 units subcutaneous at bedtime, effective 7-25-19. The MAR indicated the resident did not receive the insulin on 12-7,8-2019 due to medication not available.	S3200		

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 _____	C 12/12/2019

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
S3200	Continued From page 27 During an interview on 12-11-19 at 11:52 AM licensed nursing staff B reported when medications are not available the medication aide is to call the pharmacy to see what is going on and try to get it in the facility that day. They also need to call the nurse and let her know. The operator failed to ensure staff followed standards of practice regarding administering medications according to physicians orders. - Review of resident #134's medical record revealed she admitted to the facility on 8-6-19 with diagnoses of diabetes type 2, mild cognitive dysfunction, hypertension, depression and anxiety. Review of the resident's functional capacity screen dated 9-21-19 revealed the resident could not manage her own medications and medical treatments. Review of the resident's negotiated service agreement dated 8-7-19 revealed the community staff to manage the residents medications and blood sugar monitoring as ordered. Review of the signed medical providers order sheet for November 2019 included an order for Mirtazapine (an antidepressant) 7.5 mg at bedtime. Review of the resident's December 2019 medication administration record (MAR) revealed staff administered the medication on 12-1-19 and did not administer it 12-2,3,4,5,6,7,8,9-2019 due to medication not available.	S3200		

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 _____	C 12/12/2019

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
S3200	Continued From page 28 During an interview on 12-11-19 at 11:52 AM licensed nursing staff B reported when medications are not available the medication aide is to call the pharmacy to see what is going on and try to get it in the facility that day. They also need to call the nurse and let her know. Requested policies on 12-12-19 for administration of medications and one was not provided. The operator failed to ensure staff followed standards of practice regarding administering medications according to physicians orders.	S3200		
S3202 SS=E	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR-26-41-205(d)(4) The facility reported a census of 34 residents. The sample included 3 residents and 3 focused record reviews. Based on interview and record review of 3 certified medication aide employee files the operator failed to ensure the delegation of the nursing procedure of administration of dialing and priming an insulin pen for certified medication aides under the Kansas nurse practice act, K.S.A.65-1124 and amendments thereto. This had the potential to affect all residents who had staff dialed an insulin pen to	S3202		

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 _____	C 12/12/2019

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
S3202	Continued From page 29 the proper insulin dosage for the resident to self-inject. Findings included: - Review of 3 certified medication aide employee records revealed certified staff C, G, and H did not have evidence of licensed nurse delegation for dialing and priming an insulin pen. The dialing of an insulin pen to the ordered dosage is not part of the medication aide state ciriculim. During an interview on 12-9-19 at 1:16 PM certified staff C reported the medication aide dialed the residents insulin pen to the ordered dose to get it ready for the resident to self inject. During an interview on 12-11-19 at 9:15 AM operator A reported she did not have any records of delegation for certified medication aides for dialing of insulin pens to the proper dosage. The operator failed to ensure designated staff ensure the delegation of the nursing procedure of administration of dialing and priming an insulin pen for certified medication aides under the Kansas nurse practice act, K.S.A.65-1124 and amendments thereto.	S3202		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (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	S3211		

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 _____	C 12/12/2019

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
S3211	Continued From page 30 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: - During observations of the medication room with certified staff C on 12-9-19 at 12:50 AM revealed medication cart for hall 2 had the following over the counter medications with a resident room number only or resident initials or no name at all on the bottle: 2 bottles of Aspirin 81 mg, Calcium 600 + vitamin D, Vitamin D 500 mg, Vitamin C 1000 mg, Iron 325 mg, All day allergy medication, Bayer low dose, Acidophilus probiotic, Fish oil 1000 mg, Calcium 600 mg, Pureform Bio-function supplement, liver function supplement, vital guard supplement and a bottle of Aspirin 81 mg in the memory care unit medication cart. During an interview on 12-9-19 at 12:52 AM certified staff C stated over the counter medications should have had the resident's full	S3211		

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 _____	C 12/12/2019

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
S3211	Continued From page 31 names on the bottles. 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. (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	S3214		

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 _____	C 12/12/2019

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
S3214	Continued From page 32 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. 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, 3 focused record reviews. Based on observation, interview and record review the operator failed to ensure 1 (##129) of 1 resident who received sample medications included the following conditions: Operator ensured the development of policies and 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;	S3214		

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 _____	C 12/12/2019

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
S3214	Continued From page 33	S3214		

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 the information and accepted the risk of potential adverse consequences.

Findings included:

- Review of resident #129'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 9-12-19 revealed the resident was independent with medication administration and treatment management.

Review of the residents negotiated service agreement/health care service plan dated 10-17-19 revealed the facility would manage the resident medications until a self-administration assessment could be completed.

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 _____	C 12/12/2019

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
S3214	Continued From page 34 Review of the physicians order revealed an order dated 9-23-19 for Eliquis 5 milligrams (mg) 1 tablet twice a day. Observation on 1-9-19 at 12:50 PM of medication cart hall 2 revealed a box of Eliquis 5 mg tablets without a residents name on the box, how, when, or how many to take or the medical provider that ordered the medication. During an interview on 12-9-19 at 12:52 PM certified staff C stated the resident would bring the boxes of medication back with him after going to the physician. Staff C opened the overflow cabinet and there were 2 more boxes of Eliquis 5 mg that did not have any information on the box related to directions for administration or the physician who prescribed the medication. Staff C stated she did not do any kind of log when he gave the boxes to her. During an interview on 2-5-19 at 4:28 12-9-19 at 3:07 PM licensed nursing staff B reported she had not done anything regarding the resident's sample medications and did not have any records that she knew of. The operator failed to ensure the development of a policy regarding sample medications and the all of the appropriate information regarding the administration of sample medications for resident #129 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		

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 _____	C 12/12/2019

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
S3215	Continued From page 35	S3215		
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. (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)	S3215		

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 _____	C 12/12/2019

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
S3215	Continued From page 36 The facility reported a census of 34 residents. The sample included 3 residents and 3 focused record reviews. Based on observation and interview for all residents living in the facility and receiving medication services, the operator failed to ensure all medications that would require to be stored in a refrigerator were stored according to the manufactures recommendations. Findings included: - Observation on 12-9-19 at 12:58 PM of the refrigerator where all medications for residents were stored that required refrigeration revealed a thermometer that read 28 degrees. Medication in the refrigerator include Box of Humalog flexpens, box of Lantis flexpens, box of Trulicity flex pens and boxes of Latranoprost eye drops. Each of the boxes indicated the medications needed to be stored between 36 and 46 degrees. Review of the temperature log on the medication refrigerator on 12-10-19 at 7:28 AM revealed temperatures for the month of December between 21 degrees F and 33 degrees F. The temperature readings staff obtained were less than the manufactures recommendations thus far the month of December. On 12-10-19 at 6:45 AM the thermometer in the medication fridge read 22 degrees. Surveyor placed her thermometer in the refrigerator to identify accuracy of reading. At 7:30 AM the surveyors thermometer read 33.9 degrees which is less than manufactures recommendations. During an interview on 12-10-19 at 10:20 AM licensed nursing staff confirmed temperatures between 21 degrees F and 33 degrees F are too	S3215		

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 _____	C 12/12/2019

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
S3215	Continued From page 37 cold for the medications in the refrigerator. The operator failed to ensure medications that required refrigeration were stored at the proper temperatures according to manufacturers recommendations.	S3215		
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	S3248		

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 _____	C 12/12/2019

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
S3248	Continued From page 38 by: KAR-26-41-102 (d)(2) The facility reported a census of 34 residents. Based on interview and record review of 5 newly hired employees, the operator failed to ensure of 3 newly hired staff employee records contained supporting documentation of submission of criminal background checks upon hire for facility staff according to K.S.A.39-970 and amendments. Findings included: - Review of employee files conducted on 12-10-19 revealed the following: Certified staff F, certified staff C and certified staff G did not have record of a criminal background completed through KDADS upon hire. On 12-11-19 operator A provided the results of KDADS criminal background check for certified staff F printed on 10-24-19, over 9 months after hire date of 1-25-19. During an interview on 12-10-19 at 9:22 AM operator staff A reported initially she did not realize the criminal back ground checks needed to go through KDADS and since finding out she is going through employee charts and completing those checks. Requested policy regarding criminal background checks on 12-12-19 at 7:32 AM and was not provided. The administrator failed to ensure employee records contained supporting documentation of criminal background checks submitted upon hire.	S3248		

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 _____	C 12/12/2019

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
S3248	Continued From page 39 This had the potential to affect all residents in the facility	S3248		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 34 residents. The sample included 3 residents and 3 focused record reviews. Based on record review and interview for 3 (#130, #131, #134) of 3 residents sampled, the operator failed to ensure the resident's record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. Findings included: - Review of resident #130's medical record revealed she admitted to the facility on 1/10/15 with diagnoses of alzheimers, anxiety, and constipation. Review of the residents functional capacity screen dated 12-9-19 revealed the resident required physical assistance with all activities of	S3261		

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 _____	C 12/12/2019

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
S3261	Continued From page 40	S3261		

daily living except eating. The resident also had bladder incontinence, cognitive impairment and difficulties with communication. The resident was not able to manage her own medications and medical treatments and had recent/current problems with vision, hearing and impaired decision making.

Review of the resident's negotiated service agreement dated 2-8-18 revealed the facility staff will manage the resident's medications and medical treatments. Staff also provided physical assistance of 1 staff with all activities of daily living and supervised with eating. Staff provided reminders and prompting related to poor cognition.

Review of the resident's nurses noted revealed the following:

On 10-3-18 the resident admitted to encompass hospice services. The record lacked any communication as to why the resident started on hospice, communication with physician or durable power of attorney regarding the need for Hospice services.

On 12-9-18 the resident fell out of bed and complained of head pain. The daughter refused to send the resident to the emergency department for evaluation. The record lacked follow up assessments by the nurse related to fall with complaints of head pain.

On 12-13-19 the resident had vomiting of white foamy saliva throughout the day. Hospice nurse was notified and awaiting pharmacy to deliver Zofran for vomiting. The record lacked any follow up documentation related to the residents vomiting.

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 _____	C 12/12/2019

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
S3261	Continued From page 41 On 5-25-19 the resident had redness below breast and received order for Nystatin powder. The record lacked any follow up related to the results of the Instating powder. During an interview on 12-11-19 at 11:44 AM - licensed nursing staff B reported she expected staff to follow up after the resident had falls or signs of illness with what the nurse did for the resident and the results of those actions. - Review of resident #131's medical record revealed he admitted to the a facility on 12-9-18 with diagnoses of gout, hypertension Dementia and diabetes. Review of the resident's functional capacity screen dated 11-19-19 revealed the resident needed physical assistance with management of medications and medical treatments. The resident also needed physical assistance with bathing, dressing, and toileting and had cognitive impairment with recent problems with falls. Review of the resident's negotiated service agreement dated 6-3-19 revealed the facility would manage all of the resident's medications. Staff also provided assistance of 1 with bathing, dressing, and toileting and provided reminders and cues related to cognition. Review of the resident's nurses notes revealed the following: On 1-26-19 the resident's family member took him to the hospital. The record lacked any follow up as to the resident returning from the hospital, what treatment the resident received at the hospital, and the results of that treatment.	S3261		

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 _____	C 12/12/2019

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
S3261	Continued From page 42 On 2-28-19 the resident received antibiotic for wound to right hand. The record lacked information regarding what caused the wound, physician notification of wound and need for treatment. On 8-9-19 resident had a fall out of bed with a laceration in right eyebrow area. The record lacked follow up on fall with laceration, any treatment done for the laceration. The record lacked nurse follow up from the fall for over 48 hours. During an interview on 12-11-19 at 11:44 AM - licensed nursing staff B reported she expected staff to follow up after the resident had falls or signs of illness with what the nurse did for the resident and the results of those actions. - Review of resident #134's medical record revealed she admitted to the facility on 8-6-19 with diagnoses of diabetes type 2, mild cognitive dysfunction, hypertension, depression and anxiety. Review of the resident's functional capacity screen dated 9-21-19 revealed the resident could not manage her own medications and medical treatments. The resident required physical assistance with bathing and dressing and was independent with transfers and walking. The resident also had recent/current problems with falls, wandering, inappropriate behaviors and impaired decision making. Review of the resident's negotiated service agreement (NSA) dated 8-7-19 revealed the community staff to manage the residents	S3261		

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 _____	C 12/12/2019

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
S3261	Continued From page 43 medications and blood sugar monitoring as ordered. It revealed family assisted with bathing and the staff provided assistance with dressing. The NSA directed staff to provide redirection and reassurance, to remind resident to use walker. It failed to identify what staff needed to do for wandering or inappropriate behavior of disrobing. Review of the resident's nurses notes revealed the following: On 9-6-19 the nurse documented a fall the resident had on 9-4-19 with the resident complained of neck pain. The record lacked nurse follow up related to the fall until 9-6-19. On 11-6-19 the record the resident had a fall which resulted in her eye glasses breaking and getting a hematoma over her left eye with some bleeding. The resident went to local hospital emergency room and returned the same night. The record lacked documentation related to fall with hematoma until 11-8-19. During an interview on 12-11-19 at 11:44 AM - licensed nursing staff B reported she expected staff to follow up after the resident had falls or signs of illness with what the nurse did for the resident and the results of those actions. The operator failed to ensure the resident's records contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.	S3261		
S3290 SS=E	26-41-206 (a) (b) Dietary Services (a) Provision of dietary services. The	S3290		

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 _____	C 12/12/2019

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
S3290	Continued From page 44 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 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 3 focused record review. Based on observation, interview and record review the operator failed to ensure staff provided 3 (#130, #132, and #133) of 3 residents with a mechanical soft diet as ordered by their medical provider.	S3290		

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 _____	C 12/12/2019

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
S3290	Continued From page 45 Findings included: During initial tour of the kitchen revealed a board with resident #130, #132, and #133 identified as needing to be served a mechanical soft diet. During tour dietary staff E stated they did not have any residents who had mechanically altered/pureed diets. Staff E stated staff just had to make sure the resident's had soft food and the kitchen staff chopped it up good. - Review of resident #130's medical record revealed she admitted to the facility on 1/10/15 with diagnoses of Alzheimer, anxiety, and dysphasia. Review of the residents functional capacity screen dated 12-9-19 revealed the resident required supervision with eating. Review of the resident's most recent/current negotiated service agreement staff completed on 2-8-18 revealed staff would provide the resident a mechanical soft diet. Observation on 12-10-19 the resident sat at the table eating her breakfast and was service scrambled eggs and a sausage link that was not cut up. The resident took her left hand and picked off tiny pieces to eat the sausage. Observation revealed the resident had not teeth and did not have any dentures in her mouth. During an interview on 12-10-19 at 8:48 AM certified staff I reported the resident did not receive any special diet and she served the resident the same foods as the other residents. Observation on 12-10-19 at 12:20 PM staff	S3290		

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 _____	C 12/12/2019

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
S3290	Continued From page 46	S3290		

served the resident chipped beef and gravy served on toast and roasted potatoes chunks. Staff did not cut up the residents chipped beef or potatoes into smaller pieces and the resident did not have on her glasses or dentures.

- Review of resident #132's medical record revealed the resident admitted to the facility on 8-9-19 with diagnoses of dementia, diabetes type 2, and chronic pulmonary edema.

Review of the residents functional capacity screen dated 8-17-19 revealed the resident was independent with eating and had some cognitive impairment.

Review of the residents negotiated service agreement dated 8-16-19 revealed the resident required a mechanical soft diet due to swallowing problems.

Observations on 12-10-19 at 8:00 AM staff served the resident fried eggs, 2 strips of bacon and a piece of french toast. The resident took small tiny bites of the bacon and only ate about 25 % of her whole meal.

Observation on 12-10-19 at noon meal staff served the resident a slice of bread with chipped beef and gravy, and chunks of roasted potatoes.

- Review of resident #133's medical record revealed the resident admitted to the facility on 9-4-18 with diagnoses of Alzheimers disease, hypertension, dry mouth and epigastric pain. The resident also had a diagnoses dated 8-30-18 for decreased mastication (chewing) and signs of aspiration.

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 _____	C 12/12/2019

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
S3290	Continued From page 47 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 mechanical diet with thin liquids. Review of the resident record included a medical providers order for mechanical soft solids. Observation on 12-10-19 at 8:51 AM staff served the resident breakfast with cut up french toast, cut up eggs and a sausage link cut into approximately 1/4" pieces. Observation on 12-10-19 for lunch staff served the resident toast with chipped beef and gravy, chunks of roasted potatoes and pickled beets. For all 3 residents observations revealed staff failed to provide the residents a mechanical soft diet as ordered by their medical provider. During an interview for all 3 residents on 12-10-19 at 1:21 PM dietary staff K reported there were no directions in the kitchen on how to fix a mechanical soft diet or any approved menus from the dietitian. She thought the operator would have approved menus. During an interview on 11-19 at 9:45 AM operator staff A reported the registered dietitian doesn ' t not review the menus but just checked on stuff in the kitchen. During an interview on 12-11-19 at 11:40 AM licensed nursing staff B stated she would expect	S3290		

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 _____	C 12/12/2019

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
S3290	Continued From page 48 the dietary staff to serve residents their diets as ordered by the medical provider. Requested policies on 12-12-19 for therapeutic diets and the operator did nto provide one. The operator failed to ensure dietary staff had instructions on how to provide a mechanically soft diet and staff provided a mechanical soft diet for 3 residents as ordered by their medical provider.	S3290		
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 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 34 residents.	S3298		

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 _____	C 12/12/2019

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
S3298	Continued From page 49	S3298		

Based on observations, interview and record review affecting all residents, the operator failed to ensure staff prepared food using safe methods that conserve the nutritive value, flavor and appearance and shall be served at the proper temperature.

Findings included:

- During an interview on 12-10-19 at 7:33 AM dietary staff E reported she checked the temperature of foods but did not keep any type of log for food temperatures.

Observation on 12-11-19 at 7:30 dietary staff E delivered the "hot cart" down to the memory car unit for certified staff I to fix the residents their plates. Staff E proceeded to put scrambled eggs, bacon and/or sausage links and toast on each resident's plate.

During an interview at 7:40 AM resident #135 stated regarding the sausage links, " It is not hot, but warm". Resident #135 also reported her eggs were not hot.

Observation at 7:45 after each resident received their plate the surveyor touched the steam table pan that the food was in and they were cold. The cart was not hot. The temperature of the scrambled eggs were 105.0 degrees.

Observations of the main kitchen from 8:00 to 8:20 dietary staff E had a steam table which was on and had pans of scrambled eggs, sausage and bacon in them. At 8:20 staff E reported she kept the food on the steam table till all of the resident's are served their breakfast.

At 8:25 all residents had been served and

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 _____	C 12/12/2019

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
S3298	Continued From page 50 surveyor asked for 2 sample pieces of sausage. The temperature of 1 read 110.6 degrees F and the other one read 105.8 F. Staff E took the temperature of a piece of sausage in the steam table tray and it read 125 degrees F. Staff E reported the temperature of the sausage needed to be 145 degrees F. Review of the food safety code revised August 2017 revealed poultry needed to be cooked to 165 degrees and pork needed to be cooked to 155 degrees. The minimum hot holding temperature for hot foods is 135 degrees F. Requested policies on 12-12-19 for food temperature monitoring and the operator did not provide one. For all residents, the operator failed to ensure staff prepared food using safe methods that conserve the nutritive value, flavor and appearance and shall be served at the proper temperature	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)	S3299		

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 _____	C 12/12/2019

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
S3299	Continued From page 51 The facility reported a census of 34 residents. Based on observations and interviews the operator failed to ensure designated dietary staff stored all food under safe and sanitary conditions. This had the potential to effect all residents who ate prepared by the facility. Findings included: - During initial tour of the kitchen on 12-9-19 at revealed an open bag of spaghetti type noodles in a baggie that was too small and the noodles had partially spilled out into the large box where stored. Observation in a freezer revealed a clear bag of onion rings that was about 1/4 full and had been opened at the top and ripped down the middle. The bag lacked a date of when opened and was not sealed. In the chest freezer there were 3 bags of chicken in their original bag but no date when the bag was frozen. There same chest freezer had bags of hamburger patties. There were 2 bags that were not sealed and were ripped in multiple places on the bags. During an interview on 12-9-19 at 1:22 PM dietary staff D reported the bag should have been sealed and dated when opened. During an interview on 12-9-19 at 1:25 PM dietary staff E reported the foods should have had a date on them and been in bags that were sealed. Requested policies on 12-12-19 for food storage and the operator did not provide one. The operator failed to ensure designated staff stored foods under safe and sanitary conditions by the failure to ensure dating and labeling of foods and improper technique of thawing frozen meats.	S3299		

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 _____	C 12/12/2019

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
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 all 3 residents and 3 focused record reviews. Based on interview and record review for 3 of 3 sampled residents (#130,#131, #134) and 3 of 5 new employee records, 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. This failure effected all residents who lived in the residential health care facility. Findings included: - Review of resident #130's record revealed she admitted to the facility on 1/10/2015 with	S3310		

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 _____	C 12/12/2019

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
S3310	Continued From page 53 diagnoses of Alzheimer's, anxiety, dysphasia, and hallucinations. Review of the resident's medical record lacked evidence the facility administered an annual TB skin test or TB questionnaire. - Review of resident #131's medical record revealed he admitted to the facility on 12-9-18 with diagnosis of Dementia, gout, hypertension, and depression. Review of the resident's medical record revealed the facility administered a one step TB skin test on 12-10-18 and a TB questionnaire on 12-10-18 but failed to administer the second TB skin test. - Review of resident #134's record revealed she admitted to the facility on 8/8/2019 with diagnoses of mild cognitive dysfunction, diabetes type 2, hypertension, depression and anxiety. Review of the resident's medical record revealed she admitted from another facility which had completed TB skin testing in June and July 2018 and did a questionnaire on 6-11-19. The record lacked evidence of current facility completing a TB questionnaire upon admission to the facility. During an interview on 12:07 PM licensed nursing staff B reported TB skin testing were to be completed on admission and annually and the questionnaire completed annually after admission. Staff B reported the resident's TB skin testing should be in their chart. - Review of 5 newly hired employees file	S3310		

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 _____	C 12/12/2019

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
S3310	Continued From page 54 revealed the following: Licensed nursing staff B Hired on 10-2-2019 and her employee record lacked evidence of a TB questionnaire upon hire. Certified staff C hired onto the facility on 1-25-19 and she did not receive her 2 step TB testing until 5-21-19, almost 4 months after hire date. Certified staff H hired onto the facility on 2-11-19 and his record lacked evidence of a 2 step TB skin test. During an interview on 12-10-19 at 9:22 AM operator staff A reported she had no other files that would contain employee TB testing information. The records revealed 3 of the 5 employees lacked TB testing according to TB guidelines. Requested policy regarding TB testing for employees and staff on 12-12-19 at 7:32 AM and was not provided. For 3 of 3 sampled residents (#200, #300, #400) and 3 new employee records, 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		