STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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 are the result of a Revisit and Correction Order 19-120 at the above named Assisted Living facility in Abilene, Kansas on 9/04/19, 9/05/19, 9/09/19, and 9/10/19.	{S 000}		
{S3080} SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a) The census equalled 26 the sample included three Residents. Based on observation, interview, and review of record, for one of three sampled (#1070), the Operator failed to ensure designated facility staff completed a functional capacity screen (FCS) on or before that individual admitted to facility. Findings included:	{S3080}		

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
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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
{S3080}	Continued From page 1 - Review of record revealed #1070 admitted to facility 7/29/19 with diagnoses of dementia, atrial fibrillation, chronic obstructive pulmonary disease, hypothyroid, macular degeneration. The record lacked a FCS completed at the time of admission to this facility. An internal assessment tool (Appendix B service assessment...) recorded #1070 in need of health care services including medications, bathing, bathroom assistance, and diabetes care. The current negotiated service agreement (NSA) dated 7/29/19 recorded interventions to address physical assistance with the activities of daily living described above. On 9/10/18 at 4:20pm Operator #F confirmed no FCS in the medical record for #1070... #F contacted out of state company Registered Nurse #E to inquire if it was completed and misplaced... at 4:50pm Operator #F confirmed no FCS in facility or available. The Operator failed to ensure designated facility staff completed an FCS at time of admission to the facility for #1070.	{S3080}		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity 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; and	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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
S3081	Continued From page 2 (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c) The census equalled 26 the sample included three Residents. Based on observation, interview, and review of record, for one of three sampled (#1080), the Operator failed to ensure designated facility staff conducted a functional capacity screen (FCS) at least once every 365 days. Findings included: - Review of record revealed #1080 admitted to facility 6/12/15 with diagnoses of hypertension, memory loss, cancer, osteoporosis, anemia, gastritis, and anemia. By review, the current and only FCS in medical record dated 02/05/18. The medical record lacked the required annual review/revision and lacked any indication of an annual review. On 9/04/19 at 5:15pm, Operator #F stated I phoned the company registered nurse/current facility nurse #E (currently out of state)... he/she has not returned my call yet... Operator #F stated I am not a "clinical" person.... wish I could help... The Operator failed to ensure designated facility staff conducted an FCS at least once every 365 days.	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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
S3101	Continued From page 3	S3101		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The census equalled 26 the sample included three Residents. Based on reviews of records and interviews, for two of three sampled (#1070 and #1011), the Operator failed to ensure each individual involved in the development of the negotiated service agreement (NSA) signed the agreement. Findings included: - Review of record revealed #1070 admitted 7/29/19 with diagnoses of dementia, atrial fibrillation, chronic obstructive pulmonary disease, hypothyroid, macular degeneration. The record lacked a functional capacity screen. The September 2019 MAR (medication administration record) documented facility staff administered medications and treatments to Resident. The current negotiated service agreement (NSA) recorded health care services to be provided as needed by facility staff.	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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
S3101	Continued From page 4 The NSA lacked the signature of a licensed nurse. - Review of record revealed #1011 admitted 5/20/19 with diagnoses of diabetes, hypertension, and history of breast cancer. The 6/19/19 functional capacity screen assessed Resident independent or in need of supervision only with health care needs. The current 8/21/19 negotiated service agreement (NSA) recorded stand by assistance with transfers, medication assistance, and supervision/assistance as needed with bathing, dressing, toileting. The NSA lacked any signatures. The NSA lacked signatures of Resident, Resident's representative, licensed nurse, or operator. On 9/04/19 at 5:15pm Operator #F confirmed no return call from attempt to contact the company registered nurse/facility nurse (currently out of state)... #F stated if it's not in the chart we don't have it. The Operator failed to ensure each individual involved in the development of the NSA for #1070 and #1011 signed the NSA.	S3101		
{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 licensed nurse or pharmacist or by a family	{S3175}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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 5 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 26-41-205(a)(1) The census equalled 26 the sample included three Residents. The Resident Roster identified 13 Residents who self administered medications. Based on interview and review of records, for three of three sampled (#1070, #1080, and #1011), the Operator failed to ensure a licensed nurse performed an assessment and determined the Resident could perform the function safely and accurately without staff assistance. Findings included: - Review of record revealed #1080 admitted to facility 6/12/15 with diagnoses of hypertension, memory loss, cancer, osteoporosis, anemia, gastritis, and anemia. Current 02/05/18 functional capacity screen (FCS) in medical record assessed #1080 independent with medications.	{S3175}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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 6 The current negotiated service agreement of 01/07/19 documented #1080 self managed all medications. The September 2019 MAR (medication administration record) remained blank with no staff initials for administration. The medical record contained an outdated self administration assessment. The assessment dated 02/05/18 not completed annually as required. - Review of record revealed #1070 admitted to facility 7/29/19 with diagnoses of dementia, atrial fibrillation, chronic obstructive pulmonary disease, hypothyroid, macular degeneration. The record lacked a FCS completed at the time of admission to this facility. An internal assessment tool (Appendix B service assessment...) recorded #1070 in need of health care services including medications management. The current negotiated service agreement (NSA) dated 7/29/19 recorded interventions for facility management of medications. The September 2019 MAR (medication administration record) documented facility administration of most medications. The MAR noted self administration of Icy Hot (roll on analgesic) and normal saline nasal spray. The NSA documented self administration of nebulizer breathing treatments after staff set up unit. The medical record lacked a self administration	{S3175}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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 7 assessment of #1070's abilities for the nebulizer treatments, Icy Hot analgesic, and the normal saline nose spray. On 9/10/18 at 4:20pm Operator #F confirmed no self administration assessment in the medical record for #1070... #F contacted out of state company Registered Nurse #E to inquire if it was completed and misplaced... at 5:12pm Operator #F confirmed no FCS in facility or available. - Review of record revealed #1011 admitted 5/20/19 with diagnoses of diabetes, hypertension, and history of breast cancer. The 6/19/19 functional capacity screen assessed Resident in need of supervision only with medications and treatments. The current 8/21/19 negotiated service agreement (NSA) recorded staff to apply Calmoseptine to buttock wound. The September 2019 MAR (medication administration record) recorded staff administration of all oral medications and application of Calmoseptine and also A & D ointment to buttocks. The medical record contained a self-med assessment dated 6/19/19. This form with hand written note at the bottom "home health prefills med planner 7 days at a time... pharmacy is set to auto refill... facility staff applies lotion." By review this self med assessment incomplete. The following areas of assessment remained blank: "Can tell time and when Rx is due"; "Can read Rx label and say name of Rx";	{S3175}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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 8 "Know why they take each Rx"; "Can state and report side effects of Rx." The Operator failed to ensure a licensed nurse performed an assessment of #1080, #1070, and #1011, and determined the Resident could perform the function of medication self administration safely and accurately without staff assistance.	{S3175}		
S3200 SS=D	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: KAR 26-41-205(d) The census equalled 26 the sample included three Residents. The Resident Roster identified	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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 9	S3200		

13 with facility managed medications. Based on interview and review of record, for one of two sampled Residents with facility managed medications (#1070), the Operator failed to ensure all medications and biological's administered to Residents in accordance with a medical care provider's written orders and in accordance with professional standards of practice.

Findings included:

- Review of record revealed #1070 admitted to facility 7/29/19 with diagnoses of dementia, atrial fibrillation, chronic obstructive pulmonary disease, hypothyroid, macular degeneration.

The record lacked a FCS completed at the time of admission to this facility.

An internal assessment tool (Appendix B service assessment...) recorded #1070 in need of health care services including medications.

The current negotiated service agreement (NSA) dated 7/29/19 recorded interventions to address physical assistance with medications.

Comparison of the September 2019 MAR with current written physician's orders revealed discrepancies.

Admission medication orders consisted of a blank "Physician Plan of Care" form, page 04 of 006. This blank page contained spaces for medication, dose, route, frequency, diagnosis, dispense number, refill number, and substitution permitted. This blank page contained the notation "additional pages may be attached; all pages must be signed." There were no pages attached in the six

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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 10	S3200		

page fax.
An unattached list of orders "as of 07/30/19" (approximate time of admission) lacked a physician signature.

This list of medications included "Maxivision whole body". This unsigned note lacked the dose, route, and frequency of the Maxivision.
The Maxivision observed on the September 2019 MAR as Maxivision multivitamin/eye vitamin 2 capsules by mouth once daily

This same list included "Mucinex (expectorant) one tab BID (twice daily)" This note lacked the dose and the route.
The Mucinex observed on the September 2019 MAR as Mucinex 600mg (milligrams) one tablet by mouth twice daily for COPD (chronic obstructive pulmonary disease).

This same list included "Stool softener" and "Nasal Spray." The note lacked the dose, route, and frequency for these.
The Stool Softener observed on the September 2019 MAR as "Colace 100mg capsule one capsule by mouth twice daily as needed for constipation."
The Nasal Spray on the September 2019 MAR as "saline nasal spray apply to nares as needed for dryness, may have in room."

The medical record contained an order dated 7/08/19 at top of page, signed by physician 8/07/19, noted by licensed nurse 8/12/19: "Ativan (controlled substance anti-anxiety) 0.5mg one tab by mouth every 4 hours PRN (as needed) for anxiety."
The record lacked a physician's order to discontinue this medication.
The Ativan order not included on the September

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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 11 2019 MAR. The medical record contained an 8/06/19 prescription form signed by physician: Discontinue Aspirin Miralax (laxative) PRN is OK Icy hot in room is OK Proair MDI (multi dose inhaler) 2 puffs BID (twice daily) Can have nasal spray (saline) can keep in room Debrox (ear wax removal) drops BID for 7 days PRN ear wax removal Miralax observed on the September 2019 MAR as "Miralax 17gm (grams) powder mix with liquid once daily as needed for constipation." Icy Hot observed on the September 2019 MAR as "Icy Hot roll on analgesic may apply four times daily to affected area as needed (may self administer and keep in room)" Nasal Spray on the September 2019 MAR as "Saline nasal spray apply to nares as needed for dryness, may have in room" The September 2019 MAR lacked the Debrox order and the record lacked an order to discontinue. The medical record lacked attempts to obtain clarification for these discrepancies according to professional standards of practice. On 9/10/18 at 5:15pm Operator #F stated I phoned our out of state company Registered Nurse #E... no call back at this time... The Operator failed to ensure all medications and biological's administered to #1070, in accordance with medical care provider's written orders and in accordance with professional standards of practice.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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
{S3250} SS=E	26-41-105 (a) Resident Records a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the maintenance of a record for each resident in accordance with accepted professional standards and practices. (1) Designated staff shall maintain the record of each discharged resident who is 18 years of age or older for at least five years after the discharge of the resident. (2) Designated staff shall maintain the record of each discharged resident who is less than 18 years of age for at least five years after the resident reaches 18 years of age or at least five years after the date of discharge, whichever time period is longer. This REQUIREMENT is not met as evidenced by: KAR 26-41-105(a) The census equalled 26 the sample included three Residents. Based on review of records, for two of three sampled (#1070 and #1011), the Operator failed to ensure the maintenance of a record for each Resident in accordance with accepted professional standards and practices. Findings included: - Review of record revealed #1070 admitted 7/29/19 with diagnoses of dementia, atrial fibrillation, chronic obstructive pulmonary disease, hypothyroid, macular degeneration. The record lacked a functional capacity screen.	{S3250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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
{S3250}	Continued From page 13 The current negotiated service agreement (NSA) recorded health care services to be provided as needed by facility staff. Review of medical record "Resident Service Notes" (nurses' notes) revealed entries completed since the last resurvey failed to meet professional standards and practices. One entry of record notes dated 8/05/19 at 1300 and one entry of record notes dated 8/07/19 at 080 each lacked the signature of the licensed nurse completing the documentation. An entry on 8/07/19 at 1110 described Resident #1070 as confused, agitated, pacing. The medical record lacked an assessment of these symptoms and lacked interventions or care services provided to address the symptoms noted. Review of medical record revealed "allergies" for Resident recorded differently in different areas of record: face/information page with "Nuskin" allergy; physician's order/fax with ""Nuskin and hydrocodone"; NSA lacked the allergy to hydrocodone. The record lacked documentation of clarification attempts. On 9/04/19 at 5:15pm Operator #F stated I phoned the company registered nurse/current facility nurse #E (currently out of state)... he/she has not returned my call yet... Operator #F stated I am not a "clinical" person.... wish I could help... The Operator failed to ensure the maintenance of a record for #1070 in accordance with accepted professional standards and practices. - Review of record revealed #1011 admitted	{S3250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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
{S3250}	Continued From page 14 5/20/19 with diagnoses of diabetes, hypertension, and history of breast cancer. The 6/19/19 functional capacity screen assessed Resident independent or in need of supervision only with health care needs. The current negotiated service agreement (NSA) recorded stand by assistance with transfers, medication assistance, and supervision/assistance as needed with bathing, dressing, toileting. Review of medical record revealed "allergies" for Resident recorded differently in different areas of record: medication administration record recorded penicillin (antibiotic) and simvastin (cholesterol medication); the NSA recorded only penicillin. The record lacked documentation of clarification attempts. Review of medical record "Resident Service Notes" (nurses' notes) revealed entries completed since the last resurvey failed to meet professional standards and practices. One entry of record notes dated 7/17/19 at 0900 and one entry of 8/12/19 at 1230 each lacked the signature of the licensed nurse who completed the documentation. One entry of record notes dated 8/07/19, lacked the time of the entry, and lacked the signature of the licensed nurse who completed the documentation. An entry on 8/07/19 at 0830 documented "no fractures but is hypotensive with walking and standing... Resident admitted at this time." The medical record lacked documentation of symptoms or events that lead to an evaluation for fractures and admission to the hospital. In addition, the Resident Service Notes lacked	{S3250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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
{S3250}	Continued From page 15 completely filled pages of notes prior to starting the next page, and were not always chronologically arranged. Examples included: Page of notes with entries dated 7/15/19 and 7/17/19; The next page with dates of 7/17/19 and 7/19/19; The next page with dates of 7/19/19, 7/22/19, 7/24/19, and 7/25/19; Page of notes with entries 7/26/19, 7/29/19, and 8/07/19. The bottom six lines of page remained blank. The next page with dates of 7/31/19, 8/01/19, and 8/02/19; The next page with dates of 8/05/19 and 8/07/19; The next page with one entry 8/07/19 (eleven lines on the page) and the remainder of the page left blank. The next page of notes with entries for 8/07/19, 8/09/19, 8/12/19, 8/14/19, 8/19/19, 8/19/19. The Operator failed to ensure the maintenance of a record for #1011 in accordance with accepted professional standards and practices.	{S3250}		
{S3310} SS=D	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s	{S3310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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 16 tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(b)(5-6)(c) The census equalled 26 the sample included three Residents. Based on observation, interview, and review of record, for two of three sampled (#1080 and #1070), the Operator failed to ensure the facility's compliance with the Departments' tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Review of Resident records on 9/04/19 revealed the following: #1070 - admitted 07/29/19 - the medical record lacked required TB symptom screen and medical record lacked required two step TB skin test. #1080 - admitted 6/12/15. The medical record contained a two step skin test completed in July 2015. The medical record lacked an annual TB symptom screen. The most recent TB screen dated 8/16/18. On 9/04/19 at 5:15pm Operator #F confirmed the medical record for #1070 lacked TB testing as required at the time of admission... stated I am sure we completed that but I am not able to locate it. The Operator failed to ensure the facility's	{S3310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021008	A. BUILDING: _____ B. WING _____	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILENE PLACE SOUTH	1102 N VINE STREET ABILENE, KS 67410

(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 17 compliance with the Department's TB guidelines for adult care homes for Residents #1070 and #1080.	{S3310}		