STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named home plus facility conducted on 7/9,10,11,12,15/2019.	S 000		
S5080 SS=E	26-42-201 (a) (b) Functional Capacity Screen on Admission (a) On or before each individual ' s admission to a home plus, 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 home, 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 26-42-201(a)(b) The facility reported a census of 9 residents. The sample included all 5 residents and 2 focused record reviews. Based on record review and interview the Operator failed to ensure on or before each individual's admission to the home plus, designated staff completed a screening to determine the individual's functional capacity and record all findings on the screening form specified	S5080		

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
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5080	Continued From page 1 by the department for 4 (#700, #710, #720, #740) of 7 residents. Findings included: --- Review of resident #700's medical record revealed he/she admitted into the facility on 5/31/19 with diagnoses of hyperlipidemia, hypertensive heart disease, constipation and vitamin D deficiency. Review of the residents functional capacity screen dated 5-31-19 failed to include findings related to cognition - memory, recall. - Review of resident #710's medical record revealed he/she admitted into the facility on 6-25-19 with diagnoses of cardiac arrhythmia, seizures, and joint pain. Review of the resident's functional capacity screen dated 6-26-19, the day after he/she admitted into the facility lacked findings related to cognition, current/recent problems and risks, mobility appliance devices and had no signature of who completed the screening. - Review of resident #720's medical record revealed he/she admitted to the facility on 6-27-19 with diagnoses of major depressive disorder, anemia, reflux disease and heart disease. Review of the residents functional capacity screen dated 6-28-19, the day after admission to the facility included a cognition score of 12. - Review of resident #740's medical record revealed he/she admitted to the facility on 6-14-19 with diagnoses of hypertension,	S5080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5080	Continued From page 2 glaucoma and hypothyroidism. Review of the residents functional capacity screen that had not been electronically signed by the person who completed the screen but revealed findings entered on 6-20-19, 6 days after admission to the facility. It also included a cognition score of 8. During an interview on 7-9-19 at 2:25 PM licensed nursing staff A reported he/she thought he/she had 24 hours to complete the functional capacity screen. Staff A reported he/she did not know the new admissions were coming and would just come to work and the resident was in the building. Staff A confirmed the functional capacity screens were not completed upon admission and did not include all findings on the screening according to each element and definition. Staff A also confirmed the 2 screens had not been signed by a licensed nurse. The Operator failed to ensure the designated staff completed the Functional Capacity Screen correctly and upon admission for 4 of 7 residents.	S5080		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus 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:	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5105	Continued From page 3 (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1)(2)(3) The facility reported a census of 9 residents. The sample included 5 residents and 2 focused record reviews. Based on record review and interview the operator failed to ensure designated staff developed a written negotiated service agreement for 4 (#700, #710, #720, #740) of 7 residents based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's legal representative. --- Review of resident #700's medical record revealed he/she admitted into the facility on 5/31/19 with diagnoses of hyperlipidemia, hypertensive heart disease, constipation and vitamin D deficiency. Review of the residents functional capacity screen dated 5-31-19 failed to include findings related to cognition - memory, recall. Review of the admission negotiated service agreement revealed an electronic signature of licensed nursing staff A dated 6-6-19, 6 days after admission to the facility. It also revealed the resident would receive physical therapy from a local home health agency but did not include the involvement of skilled nursing from the agency	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5105	Continued From page 4	S5105		

and who would be responsible for payment for the service.

- Review of resident #710's medical record revealed he/she admitted into the facility on 6-25-19 with diagnoses of cardiac arrhythmia, seizures, and joint pain.

Review of the resident's functional capacity screen dated 6-26-19, the day after he/she admitted into the facility lacked findings related to cognition, current/recent problems and risks, mobility appliance devices and had no signature of who completed the screening.

Review of the residents admission negotiated service agreement revealed an agreement dated of 6-26-19 and an electronic signature of licensed nursing staff A dated 6-27-19, 2 days after admission to the facility.

- Review of resident #720's medical record revealed he/she admitted to the facility on 6-27-19 with diagnoses of major depressive disorder, anemia, reflux disease and heart disease.

Review of the residents functional capacity screen dated 6-28-19, the day after admission to the facility included a cognition score of 12.

Review of the resident's admission negotiated service agreement revealed an agreement date of 6-28-19 with information inputted into the agreement on 6-28-19, the day after admission, and electronically signed by the licensed nurse on 7-1-19, 3 days after admission. The negotiated service agreement also failed to include services licensed and certified staff would provide related colostomy care, impaired hearing, and potential

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5105	Continued From page 5 communication concerns. - Review of resident #740's medical record revealed he/she admitted to the facility on 6-14-19 with diagnoses of hypertension, glaucoma and hypothyroidism. Review of the residents functional capacity screen that had not been electronically signed by the person who completed the screen but revealed findings entered on 6-20-19, 6 days after admission to the facility. It also included a cognition score of 8. Review of the residents negotiated service agreement had an agreement date of 6-15-19, the day after admission. It also included an electronic signature of licensed nursing staff A dated 6-18-19, 4 days after admission. During an interview on 7-9-19 at 2:25 PM licensed nursing staff A reported he/she did not realize the agreement needed to be completed upon admission and confirmed the above negotiated service agreements were not completed on admission. The operator failed to ensure a negotiated service agreement was developed upon admission and identified the services the resident would receive, the provider of each service and identification of each party responsible for payment if an outside resource provided a service.	S5105		
S5116 SS=D	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5116	Continued From page 6 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, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(2) The facility reported a census of 9 residents. The sample included 5 residents and 2 focused record reviews. Based on record review and interview the operator failed to ensure the review and, if necessary, the revision of each negotiated service agreement following any significant change in condition, as defined in K.A.R. 26-39-100 for 1 (#700,) of 5 residents sampled. Findings included: -- Review of resident #700's medical record revealed he/she admitted into the facility on 5/31/19 with diagnoses of hyperlipidemia, hypertensive heart disease, constipation and vitamin D deficiency. Review of the admission functional capacity screen dated 5-31-19 revealed the resident needed physical assistance with activities of daily living except for eating and needed supervision with medication management. The resident also	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5116	Continued From page 7 had a risk of falls/unsteadiness. Review of the admission negotiated service agreement revealed an electronic signature of licensed nursing staff A dated 6-6-19 had not been reviewed or revised by licensed staff to identify the resident wore a cast and required services related to cast care. Review of the residents functional capacity screen dated 6-26-19 revealed the resident required physical assistance with all activities of daily living except eating and could not perform management of medications or medical treatments. The resident also had cognitive/memory recall deficit and at risk for falls/unsteadiness. Review of the negotiated service agreement (NSA) dated 6-27-19 after the resident had returned from a hospital stay failed to identify the services the resident required for physical assistance with dressing. IT also identified the resident's medications were set up in medication minders weekly by family and then staff handed the medications to the resident. The licensed nurse failed to review and revise the NSA when the facility staff started to administer all of the resident's medications. Staff also failed to review and revise the NSA to include interventions to promote healing of 2 pressure ulcers prevention of development of additional pressure ulcers. During an interview on 7-10-19 at 3:37 PM licensed nursing staff A reported he/she had a plan to get every resident an updated functional capacity screen and negotiated service agreement because he/she knew they were not up to date.	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5116	Continued From page 8 The operator failed to ensure designated staff reviewed and revised the negotiated service for resident #700 following any significant change in condition, as defined in K.A.R. 26-39-100.	S5116		
S5126 SS=E	26-42-202 (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 facility reported a census of 9 residents. The sample included 5 residents and 2 focused record reviews. Based on record review and interview the operator failed to ensure designated staff developed a written negotiated service agreement with each individual involved in the development of the negotiated service agreement's signature for 4 (#700, #710, #720, #740) of 7 residents. -- Review of resident #700's medical record revealed he/she admitted into the facility on 5/31/19 with diagnoses of hyperlipidemia, hypertensive heart disease, constipation and vitamin D deficiency. Review of the residents functional capacity screen dated 5-31-19 failed to include findings related to cognition - memory, recall.	S5126		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5126	Continued From page 9	S5126		

Review of the admission negotiated service agreement revealed an electronic signature of licensed nursing staff A dated 6-6-19 but did not include any other signatures of those who were involved in the development of the agreement.

- Review of resident #710's medical record revealed he/she admitted into the facility on 6-25-19 with diagnoses of cardiac arrhythmia, seizures, and joint pain.

Review of the resident's functional capacity screen dated 6-26-19, the day after he/she admitted into the facility lacked findings related to cognition, current/recent problems and risks, mobility appliance devices and had no signature of who completed the screening.

Review of the residents admission negotiated service agreement revealed an agreement dated of 6-26-19 and an electronic signature of licensed nursing staff A dated 6-27-19, but did not include any other signatures of those who were involved in the development of the agreement.

- Review of resident #720's medical record revealed he/she admitted to the facility on 6-27-19 with diagnoses of major depressive disorder, anemia, reflux disease and heart disease.

Review of the residents functional capacity screen dated 6-28-19, the day after admission to the facility included a cognition score of 12.

Review of the resident's admission negotiated service agreement revealed an agreement date of 6-28-19 with information inputted into the agreement on 6-28-19, the day after admission, and electronically signed by the licensed nurse on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5126	Continued From page 10 7-1-19, but did not include any other signatures of those who were involved in the development of the agreement. - Review of resident #740's medical record revealed he/she admitted to the facility on 6-14-19 with diagnoses of hypertension, glaucoma and hypothyroidism. Review of the residents functional capacity screen that had not been electronically signed by the person who completed the screen but revealed findings entered on 6-20-19, 6 days after admission to the facility. It also included a cognition score of 8. Review of the residents admission negotiated service agreement had an agreement date of 6-15-19, the day after admission. It also included an electronic signature of licensed nursing staff A dated 6-18-19, but did not include any other signatures of those who were involved in the development of the agreement. During an interview on 7-9-19 at 10:45 AM licensed nursing staff A reported he/she completed the negotiated service agreements (NSA) with the resident's family and type the names on the negotiated service agreement of those involved. Staff A would then compare the NSA with the functional capacity screen (FCS) to make sure it was accurate according to the FCS. Staff A would then make any changes to the NSA as needed and then send it to the family for signatures. During an interview on 7-10-19 at 10:26 AM licensed nursing staff A agreed the negotiated service agreements had not been signed by all individuals involved in the development of the	S5126		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5126	Continued From page 11 negotiated service agreement. Staff A stated the resident and sometimes the family or power of attorney are involved and he/she had not printed out the service agreements for them to sign. The operator failed to ensure each individual involved in the development of the negotiated service agreement shall sign the agreement.	S5126		
S5155 SS=G	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus 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 9 residents. The sample included 5 residents and 2 focused record reviews for safety. Based on observation, interview, and record review for 4 of 7 sampled residents (#700, #730, #750, #760), the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that meet the needs of and were in accordance with the functional capacity screen and negotiated service agreement related to skin conditions and bed rails. For resident #700 who required physical assistance of staff with activities	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5155	Continued From page 12	S5155		

of daily living, the licensed nurse further failed to ensure this resident with casts and limited mobility had interventions to reduce the risk of impaired skin integrity and when the resident developed pressure ulcers, failed to implement measures for ongoing monitoring and interventions to promote healing and reduce the risk of further worsening or development of other pressure ulcers.

Findings included:

- Review of resident #700's medical record revealed he/she moved into the facility on 5/31/19 with diagnoses of hyperlipidemia, hypertensive heart disease, constipation and vitamin D deficiency.

Review of the resident's functional capacity screen (FCS) dated 5-31-19 revealed the resident required physical assistance with activities of daily living, including transfers, toileting, walking/mobility, and dressing. The resident was continent and had problems with falls/unsteadiness. The resident also used a walker and wheelchair.

Review of the resident's FCS completed on 6-20-19 revealed now had a brace/prostheses (cast). It also revealed the resident had a recent fall and fractured knee.

Review of the resident's FCS dated 6-26-19 identified the resident had impaired cognition and did not have a brace/prosthesis.

Review of the resident's admission negotiated service agreement/health service plan initiated (NSA/HSP) on 5-31-19 and completed on 6-6-19 revealed staff needed to check the resident's skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5155	Continued From page 13	S5155		

with bathing and report any reddened/open areas to the nurse. It revealed the staff needed to assist the resident with toileting including transfer to wheelchair then to toilet. It revealed the resident used a walker and wheelchair for mobility and was not ambulatory due to knee fracture. The resident could not get in or out of bed, chair without total physical assistance of staff or with cueing. The resident received physical therapy services through a local home health agency. The NSA/HSP lacked interventions for staff to provide cast care and to address the resident's risk for development of pressure ulcers and lacked interventions after the resident developed a pressure ulcer related to the cast and also developed a coccyx pressure ulcer.

Review of a physician order in the residents paper record revealed the following " ...Please begin physical therapy 2-3 times a week for 6 weeks. Also, please begin daily wound care for ulcer on proximal thigh. If you have any questions, please feel free to call ..." The resident record lacked any additional physician orders regarding the treatment of the resident's pressure ulcers.

Review of the resident's electronic medical record included a skin assessment dated 6-21-19 completed by licensed nursing staff A, which identified a stage 2 coccyx pressure ulcer measuring 1.5 x .5 (no identification as to what type of measurement used) and also a stage 2 ulcer on left thigh related to the resident cast measuring 1 x 3/4. (no identification as to what type of measurement used). The residents medical record lacked any other assessment by the facility staff of the resident's wounds and lacked any documentation in the nurses notes regarding the cast, development of pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5155	Continued From page 14 ulcers or physician notification of the development of pressure ulcers. Review of the home health notes revealed the following: 6-7-19 visit frequency increased due to cast placed on left hip to toes. 6-9-19 education to call physician if cast feels to tight or gets a foul odor. 6-11-19 Resident complained of left upper lateral thigh pain, staff informed and would notify the nurse. 6-13-19 resident having x-rays of left leg today and has appointment with physician tomorrow. Education provided not to stick anything down the cast or get it wet. 6-21-19 therapy notes educated resident of the risk of sleeping in chair for prolonged periods as he/she has skin breakdown on buttocks. 6-29-19 skilled nursing assessment / wound care - wound care done as ordered 6-30-19 skilled nursing assessment/wound care. 7-5-19 area to coccyx is closed, will continue to put foam on area to protect new skin. The medical record lacked any additional documentation regarding the resident's pressure ulcers or interventions staff were to do to prevent worsening or reducing risk of development of additional ulcers. Observation on 7-11-19 at 4:42 PM with licensed nursing staff H revealed a foam dressing on the resident's coccyx and when removed revealed intact skin. The back of the residents left leg, just above the cast had a foam dressing and when staff H pulled the dressing back revealed a small area, approximately .2 centimeters in diameter that had a scab on it. There was not drainage on the dressing.	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5155	Continued From page 15 During an interview on 7-10-19 at 11:04 AM licensed nursing staff A reported the resident did not have any wounds upon admission to the facility and did not get any until the cast was put on. The facility staff noticed the sore on the resident's coccyx and staff A notified the home health agency about it. Staff A reported he/she had observed the wound but did not do any assessment of the wound since the home health agency was taking care of the wound. During an interview on 7-11-19 at 8:33 AM certified staff D reported the resident needed assistance with all cares. Staff stated he/she did not know if the resident still had pressure ulcers but knew he/she had one on her coccyx. Staff D stated he/she tried to get the resident to lay down in bed and he/she now had an air pad in the recliner. Staff D stated the ulcer on his/her coccyx was noticed by staff the night before he/she went to the hospital on 6-21-19. During an interview on 7-11-19 at 8:34 AM certified staff AC reported the ulcer on the resident's butt is healed but home health had a patch on it to make sure it didn't come back again. The ulcer on the resident's leg also had a patch on it and it is still open. Staff C said that staff try to off load pressure and monitor the resident's skin during bathing. During an interview on 7-11-19 at 10:06 AM licensed nursing staff A reported the residents wound treatments were a special type of dressing on the coccyx and then a protective dressing on the leg to protect it from the cast. Staff A reported, he/she did not know what kind of treatments the home health agency was supposed to be doing or how often it needed to be done. Staff A reported he/she observed the	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5155	Continued From page 16	S5155		

treatments to the wound but did not document what he/she observed. Staff A also reported he/she had not implemented any type of interventions for the facility staff to do to prevent pressure ulcers or to promote the healing of the ulcers the resident developed.

For resident #700, the operator failed to ensure the licensed nurse provided or coordinated the necessary health care services to meet his/her needs related to risk for skin breakdown. Resident #700 developed 2 pressure ulcers. The licensed nurse further failed to implement measures to monitor the wounds, promote healing and address the risk for further skin breakdown.

- Review of resident #730's medical record revealed the resident admitted to the facility on 4/24/18 with diagnoses of hypertension and major depressive disorder.

Review of the resident's functional capacity screen dated 10-23-18 revealed the resident required supervision with transfers and physical assistance with mobility.

Review of the negotiated service agreement electronically signed by licensed nursing staff I on 10-29-19 had no signatures for collaboration with resident and/or responsible party and did not include a hand cane on the bed as an assistive device for bed mobility.

Review of the resident's record lacked an assessment for safety and resident ability to use the hand cane properly.

Observation on 7-11-19 at 9:22 AM revealed a hand cane at the head of the resident's bed. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5155	Continued From page 17	S5155		

cane fit the bed tightly and gaps were within guidelines.

- Review of resident #750's medical record revealed he/she admitted to the facility on 2-9-18 with diagnoses of parkinsons and osteoarthritis.

Review of the resident's functional capacity screen dated 6-12-19 revealed the resident required physical assistance with toileting, dressing, and bathing. The resident also had a risk of falls/unsteadiness and used a mobility appliance/device.

Review of the resident's negotiated service agreement dated 6-12-19 electronically signed by licensed nursing staff A did not include any signatures for collaboration with the resident and/or responsible party. It also did not include the use of 2 bed canes the resident used to aide in bed mobility.

Observation on 7-11-19 at 9:10 AM revealed 2 hand canes on one side of the residents bed in the shape of an upside down "U". Each bar had a gap in the middle of the bar greater than 4 3/4 inches. Both of the bars easily slid when pushed or pulled on causing a large gap between the mattress and the rail causing a potential entrapment risk.

During an interview on 7-11-19 at 9:11 AM the resident reported he/she used the rails when he/she lived at home and could not do without them. The resident stated when he/she used the rails they slid out from the bed a little but they were easy to push back in.

- Review of resident #760's medical record revealed the resident admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5155	Continued From page 18 2-24-18 with diagnoses of parkinsons, major depressive disorder and vertigo. Review of the resident's functional capacity screen dated 12-17-18 revealed the resident needed supervision with transfers and mobility. The resident also had cognitive impairment and had a risk of falls/unsteadiness. Review of the resident negotiated service agreement/health service plan dated 12-17-18 did not include the use of bed canes and or their purpose. Observation on 7-11-19 at 9:22 AM revealed the resident had 2 hand rails on the left side of the resident's bed with an upside down "U" shape with a gap between the bars and the mattress greater than 3 3/4 inches. During an interview on 7-11-19 at 9:28 AM licensed nursing staff A reported he/she and administrative staff G had discussed hand canes as far as determining if the canes were a restraint or not. Staff A stated he/she had not done any type of assessment for safety related to gaps or resident ability to use safely. The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3-10-06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5155	Continued From page 19 measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. The operator failed to ensure designated staff assessed hand canes and/or bed rails for safety which included resident ability to use safely and gaps which could pose a risk of entrapment.	S5155		
S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(f) The facility reported a census of 9 residents. Based on observations and interview the facility failed to store all food under safe and sanitary conditions. This failure had the potential to affect all residents in the facility. Findings included: During initial tour on 7-9-19 at 8:50 AM the following was observed: An open package of applesauce dated 5-2 A bowl labeled "hotdogs" dated 7-6-19 use by 7-9-19 A gallon of milk dated best by 7-7-19 which was	S5195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5195	Continued From page 20 half full A plastic baggie of a type of molded meat with no label or date when opened A pitcher of tea, 1/4 full with no label A container of tapioca pudding dated 7-5-19 use by 7-7-19 A container of red, fruit jello with no label A plastic container with ice and a small scoop with the handle touching the ice cubes. During an interview on 7-9-19 at 8:56 AM certified staff D reported the baggie of meat was not in the refrigerator yesterday and did not know what or whose it was. Staff D also confirmed food was supposed to be dated and labeled for staff to know when to throw it out. . The operator failed to ensure all food was stored under safe and sanitary conditions.	S5195		
S5230 SS=F	26-42-207 (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; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5230	Continued From page 21 This REQUIREMENT is not met as evidenced by: KAR 26-42-207(c) The facility reported a census of 9 residents. The sample included 5 residents and 2 focused record reviews. Based on review of 4 (#700, #710, #720, #740) of 5 sampled residents, licensed nursing staff A failed to ensure the home's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for 4 of 5 sampled residents. Findings included: -- Review of resident #700's medical record revealed he/she admitted into the facility on 5/31/19 with diagnoses of hyperlipidemia, hypertensive heart disease, constipation and vitamin D deficiency. Review of resident #710's medical record revealed he/she admitted into the facility on 6-25-19 with diagnoses of cardiac arrhythmia, seizures, and joint pain. Review of resident #720's medical record revealed he/she admitted to the facility on 6-27-19 with diagnoses of major depressive disorder, anemia, reflux disease and heart disease. Review of resident #740's medical record revealed he/she admitted to the facility on 6-14-19 with diagnoses of hypertension, glaucoma and hypothyroidism. Review of each resident's medical record (#700, #710, #720, #740) lacked evidence of TB skin	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5230	Continued From page 22 testing or TB questionnaire in their electronic medical record or in their paper chart. During an interview on 7-9-19 at 2:20 PM licensed nursing staff A reported he/she had not don the admission TB testing for the above residents and knew he/she still needed to complete the skin testing. Based on review of 4 (#700, #710, #720, #740) of 5 sampled residents, licensed nursing staff A failed to ensure the home's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for 4 of 5 sampled residents.	S5230		
S5251 SS=E	26-42-105 (f) (11) Resident Records 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 26-42-105(f)(11) The facility reported a census of 9 residents The sample included 5 residents and 2 focused record reviews. Based on interview and record review the operator failed to ensure the record contained documentation of all incidents, symptoms, and other indications of illness or injury for 4 (#700, #710, #720, #740) of 5 sampled residents.	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5251	Continued From page 23 Findings included: -- Review of resident #700's medical record revealed he/she admitted into the facility on 5/31/19 with diagnoses of hyperlipidemia, hypertensive heart disease, constipation and vitamin D deficiency. Review of the residents functional capacity screen dated 6-26-19 revealed the resident required physical assistance with all activities of daily living except eating and also had impaired cognition and risk of falls/unsteadiness. Review of the negotiated service agreement dated 6-26-19 revealed the resident required assistance with bathing, and other activities of daily living. Review of the resident's nurses notes admission noted into the facility, did not identify the resident went to the physician and had a cast put on his/her left leg, and did not include any information regarding the resident's development of 2 pressure ulcers, the treatment of them and results of the treatment. The record included a note dated 6-26-19 that the resident returned from a local hospital where he/she had been since 6-21-19. The record lacked documentation of the resident leaving the home plus and going to the local hospital, including any symptoms the resident had prior to leaving the facility. During an interview on 7-10-19 at 11:04 AM licensed nursing staff A reported the resident came into the facility without her knowledge he/she was coming and he/she didn't write any documentation regarding the residents wounds because the home health agency managed the wounds. Staff A confirmed he/she should have	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5251	Continued From page 24	S5251		

included admission, cast, and wound information in the resident's nurses notes.

- Review of resident #710's medical record revealed he/she admitted into the facility on 6-25-19 with diagnoses of cardiac arrhythmia, seizures, and joint pain.

Review of the resident's functional capacity screen dated 6-26-19, identified the resident was unable to perform bathing, and required physical assistance with dressing. The resident could not manage his/her medications or medical treatments. The functional capacity screen did not include information regarding the residents cognitive status, recent problems/risks or his/her use of mobility assistive devices.

Review of the residents admission negotiated service agreement revealed an agreement dated of 6-26-19 revealed the resident required assistance with bathing, had a history of falls and needed supervision with ambulation. The service agreement did not identify the resident needed assistance with dressing like the functional capacity screen indicated.

Review of the residents nurses notes revealed there were no record. The record lacked information regarding admission into the facility.

- Review of resident #720's medical record revealed he/she admitted to the facility on 6-27-19 with diagnoses of major depressive disorder, anemia, reflux disease and heart disease.

Review of the residents functional capacity screen dated 6-28-19 revealed the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5251	Continued From page 25	S5251		

required physical assistance with bathing, supervision with dressing and toileting and could not manage his/her medications or medical treatments.

Review of the resident's admission negotiated service agreement revealed an agreement date of 6-28-19 revealed staff provided assistance in and out of the shower, managed his/her medications but did not include information regarding the services staff would provide regarding management of the resident's colostomy.

Review of the resident's nurses notes failed to include documentation of the resident's admission into the facility.

- Review of resident #740's medical record revealed he/she admitted to the facility on 6-14-19 with diagnoses of hypertension, glaucoma and hypothyroidism.

Review of the residents unsigned functional capacity screen revealed the resident was independent with activities of daily living but could not manage his/her medications and needed supervision with medical treatments.

Review of the residents admission negotiated service agreement had an agreement date of 6-15-19 revealed the resident required daily supervision with medications.

Review of the residents record lacked any documentation of the residents admission into the facility.

The operator failed to ensure designated staff included documentation of all incidents,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5251	Continued From page 26 symptoms and other indications of illness of injury including the date, time of occurrence, action taken, and results of the action.	S5251		
S5310 SS=E	26-42-205 (e) (f) (g 1 - 3) Medication Orders, Ordering, Labeling (e) Medication orders. Only a licensed nurse or a licensed pharmacist may receive verbal orders for medication from a medical care provider. The licensed nurse shall ensure that all verbal orders are signed by the medical care provider within seven working days of receipt of the verbal order. (f) Standing orders. Only a licensed nurse shall make the decision for implementation of standing orders for specified medications and treatments formulated and signed by the resident ' s medical care provider. Standing orders of medications shall not include orders for the administration of schedule II medications or psychopharmacological medications. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(e) The facility reported a census of 9 residents. The sample included 5 residents and 2 focused record reviews. Based on record review and interview for 4 (#700, #710) of 5 sampled residents, the operator failed to ensure that a licensed nurse or licensed pharmacist received verbal orders for medication from a medical care provider and that all verbal orders were signed by the medical care provider within seven working	S5310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5310	Continued From page 27 days of receipt of the verbal order. Findings included: -- Review of resident #700's medical record revealed he/she admitted into the facility on 5/31/19 with diagnoses of hyperlipidemia, hypertensive heart disease, constipation and vitamin D deficiency. Review of the residents functional capacity screen dated 6-26-19 revealed the resident could not perform management of medications or medical treatments. Review of the negotiated service agreement dated 6-26-19 revealed the resident required nurse delegation of medication administration to a certified aide. Review of the resident's medical record included the following telephone/fax orders that had not been signed by a medical provider within 7 days of the order; 5-31-19 - admit to home plus with standing orders per doctors nurse, copy attached. 5-31-19 - resident may leave medications in his/her apartment and administer to self as he/she had been doing in independent living 5-31-19 - Resident may continue the following; ASA 81 mg 1 daily, Lisinopril 5 mg daily, pravastatin 40 mg at hs, ibuprofen 200 mg 2 every 6 hours as needed for pain, Tramadol 37.5-325 mg 1 twice a day. During an interview on 7-9-19 at 2:20 PM licensed nursing staff A reported he/she had faxed orders to the physician but he/she had not sent them back yet. Staff A acknowledged the orders should be signed by the medical provider	S5310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5310	Continued From page 28 within 7 days. - Review of resident #710's medical record revealed he/she admitted into the facility on 6-25-19 with diagnoses of cardiac arrhythmia, seizures, and joint pain. Review of the resident's functional capacity screen dated 6-26-19, identified the resident was unable to perform bathing, and required physical assistance with dressing. The resident could not manage his/her medications or medical treatments. The functional capacity screen did not include information regarding the residents cognitive status, recent problems/risks or his/her use of mobility assistive devices. Review of the residents admission negotiated service agreement revealed an agreement dated of 6-26-19 revealed the resident required assistance with bathing, had a history of falls and needed supervision with ambulation. The service agreement did not identify the resident needed assistance with dressing like the functional capacity screen indicated. Review of the residents record lacked a medical providers orders for admission or medication for the facility staff to administer. During an interview on 7-10-19 at 9:34 AM licensed nursing staff A reported he/she thought administrative staff G had obtained an order to admit the resident to home plus with current medications and so Staff A faxed that order to the physicians office but had not received it back signed yet. Or was not signed within the 7 days after receiving the order. During an interview on 7-10-19 at 9:43 AM	S5310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5310	Continued From page 29 administrative staff G reported the facility got a verbal from the resident's medical provider to admit to the facility with current medications and that he/she had taken that order form the provider's office. Staff G confirmed he/she was not a licensed nurse. The operator failed to ensure a licensed nurse or licensed pharmacist received verbal orders for medication from a medical care provider and that all verbal orders were signed by the medical care provider within seven working days of receipt of the verbal order.	S5310		
S5315 SS=E	26-42-205 (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 home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home 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.	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5315	Continued From page 30 (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 home. (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 26-42-205(h) The facility reported a census of 9 residents. The sample included 5 residents and 2 focused record reviews. Based on observations and interviews the Operator failed to all medications and biologicals were securely and properly stored in accordance with each manufacturer's recommendations. Findings included: - Observation of medication refrigerator on 7-9-19 at 9:18 AM revealed one vial of tuberculin solution that staff did not label with an open date. During an interview on 7-9-19 at 10:35 AM licensed nursing staff A reported he/she thought it had last been used in late June. Staff A stated is should have had a date on it when it was opened. During an interview on 7-11-19 at 12:00 PM licensed nursing staff A reported the TB vial had 2 doses left because he/she administered 2 resident TB skin test with it.	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5315	Continued From page 31 Per Tubers package directions noted a vial of tubersol which has been entered and in use for 30 days should be discarded. The Operator failed to ensure the Licensed nurse storede all medications and biologicals securely and properly in accordance with each manufacturer's recommendations related to tubersol vial expirations.	S5315		
S5320 SS=E	26-42-205 (k) Medication Clinical Records (k) Clinical record. The administrator or operator, or the designee, shall ensure that the clinical record of each resident for whom the home manages the resident ' s medication or prefills medication containers or syringes contains the following documentation: (1) A medical care provider ' s order for each medication; (2) the name of the pharmacy provider of the resident ' s choice; (3) any known medication allergies; and (4) the date and the 12-hour or 24-hour clock time any medication is administered to the resident. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(k) The facility reported a census of 9 residents. The sample included 5 residents and 2 focused record reviews. Based on record review and interview for 3 (#710, #720, #740) of 5 residents,	S5320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5320	Continued From page 32 the Operator failed to ensure each residents record whom the home managed their medications contained a medical care provider's order for each medication. Findings included: --- Review of resident #710's medical record revealed he/she admitted into the facility on 6-25-19 with diagnoses of cardiac arrhythmia, seizures, and joint pain. Review of the resident's functional capacity screen dated 6-26-19 revealed the resident was unable to perform management of his/her medications and medical treatments. Review of the resident's admission negotiated service agreement signed by nursing staff on 6-27-19 revealed the resident required assistance with ordering medications and required nurse delegation of medications to an aide. Review of the resident's July medication administration record revealed the facility staff administered the following medications to the resident: Digoxin 0.25 mg daily for cardiac arrhythmia Metoprolol Tartrate 25 mg give 0.5 tablet daily for cardiac arrhythmia Levetiracetam 250 mg tablet twice a day for seizures Tylenol 8 hour arthritis pain tablet extended release 650 mg give 2 tablets twice a day for joint pain Review of the resident's medical record it did not include any history and physical with physician orders, telephone physician orders, or other type of physician orders for the medications the facility	S5320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5320	Continued From page 33 staff were administering to the resident. During an interview on 7-10-19 at 9:34 AM licensed nursing staff reported administrative staff G may have the physicians orders for medications since he/she took to order to admit the resident. Staff A reported he/she had faxed the physician with a list of the medications they were administering and had not received the order back from the physician yet. - Review of resident #720's medical record revealed he/she admitted to the facility on 6-27-19 with diagnoses of major depressive disorder, anemia, reflux disease and heart disease. Review of the residents functional capacity screen dated 6-28-19 revealed the resident could not perform management of his/her medications or medical treatments. Review of the resident's admission negotiated service agreement revealed an agreement date of 6-28-19 revealed the resident was unaware of his/her need to take prescribed medications and needed help with medications due to cognitive loss. The resident also required nurse delegation of medications to an aide. Review of the July 2019 medication administration record revealed facility staff administered the following medications to the resident: Aspirin 81 mg in the morning for heart disease Ferrous sulfate 325 mg in the evening for iron deficiency anemia Lipitor 20 mg in the evening for hyperlipidemia Magnesium (no dosage) 2 tablets in the evening for constipation	S5320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5320	Continued From page 34 Memantine HCL 5-10 mg in the evening for dementia Mirtazapine 7.5 mg at bedtime for depressive disorder Montelukast sodium 10 mg in the evening for cough Potassium gluconate 550mg 1 tablet in the morning related to vitamin deficiency Prednisone tablet (no dosage) give 2 tablets in the morning related to ulcerative colitis Docu soft capsule 100 mg 1 capsule twice a day for constipation Fluticasone 1 spray in both nostrils twice a day for allergic rhinitis Gabapentin capsule (no dosage) give 1 capsule by mouth two times a day for neuralgia and neuritis Mesalamine give 1 tablet twice a day for ulcerative colitis Tylenol (no dosage) give 1 tablet twice a day for pain Fexofenadine HCL give 1 tablet every 24 hours as needed for itching, wheezing. Review of the resident's medical record it did not include any history and physical with physician orders, telephone physician orders, or other type of physician orders for the medications the facility staff were administering to the resident. Staff A provided a fax with cover sheet dated 7-10-19 (second attempt) with a written telephone order to admit to facility home plus and continue medications as taken in independent living. The noted at the top " I have not received a signed order to admit to home plus. may we please have?" During an interview on 7-10-19 at 12:25 PM licensed nursing staff A reported he/she knew	S5320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5320	Continued From page 35 administrative staff G had gotten a verbal order to admit the resident. At 1:20 PM staff A reported the resident had provided a list of medications and the reason for taking them to him/her and that is what he/she used to put onto the MAR. - Review of resident #740's medical record revealed he/she admitted to the facility on 6-14-19 with diagnoses of hypertension, glaucoma and hypothyroidism. Review of the residents admission, unsigned functional capacity screen with entries dated 6-20-19 revealed the resident could not perform management of his/her medications and needed supervision of his/her medical treatments. Review of the residents negotiated service agreement had an agreement date of 6-15-19 revealed the resident needed help with medications due to cognitive loss, required assistance ordering medications, and required daily supervision of medications. Review of the medication administration record for July 2019 revealed facility staff administered the following medications to the resident: Levity 75 mcg daily for hypothyroidism Losartan 100 mg in the morning for hypertension Norvasc 5 mg tablet in the morning for hypertension Sensipar 30 mg in the morning for hypothyroidism Spirinolactone 25 mg in the morning for asthma Vitamin B12 1000 mcg in the morning for vitamin deficiency Vitamin D3 25 mcg in the morning for vitamin deficiency Timolol solution 0.5 % instill 1 drop in both eyes twice a day for glaucoma Albuterol sulfate nebulization solution 1 unit three	S5320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCALL MANOR	626 S 3RD ST SALINA, KS 67401

(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
S5320	Continued From page 36 time a day related to asthma Alphagan solution instill 1 drop in both eyes three times a day for glaucoma Review of the residents medical record included a physicians order dated 6-14-19 to admit to home plus related to Alzheimer disease. It did not include any orders for medications. Review of the paper and electronic record lacked physicians orders for the medications facility staff were administering. During an interview on 7-10-19 at 4:25 PM licensed nursing staff A reported the physician had not sent signed orders for the medications and he/she initiated the medication administration based on the bottles that were provided by the resident's family The Operator failed to ensure each resident had a signed medical care provider's order for each medication the facility staff administered.	S5320		