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 _____	06/20/2019

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 represent the findings of a resurvey at the above named assisted living facility conducted on 6-18-19, 6-19-19, and 6-20-19.	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: K.A.R.26-41-201(a) The facility reported a census of 26 residents. The sample included 3 residents. Based on record review the operator failed to ensure 1 (#111) of 3 residents were screened on or before the resident's admission to the facility to determine the resident's functional capacity and shall record all findings on a screening form specified by the department. 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 _____	06/20/2019

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 resident #111's medical record revealed he/she admitted to the facility on 5-20-19 with diagnoses of diabetes, obesity, hypertension and history of breast cancer. Review of the residents record included a functional capacity screen that had not been filled out. During an interview on 6-19-19 at 3:30 licensed nursing staff looked through the resident's record and reported the functional capacity screen should have been completed upon admission to the facility. The operator failed to ensure staff completed a screening on or before resident #111 admitted to the facility to determine the resident's functional capacity and recorded all findings on a screening form specified by the department.	S3080		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s	S3092		

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 _____	06/20/2019

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
S3092	Continued From page 2 family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(d)(2) The facility reported a census of 26 residents. The sample included 3 residents Based on interview and record review the operator failed to ensure designated staff reviewed, and if necessary, revised the negotiated service agreement for 2 (#119 and #124) of 3 residents following any significant change in condition, as defined in K.A.R. 26-39-100. Findings included: - Review of residents #119's medical record revealed he/she admitted to the facility on 10-15-18 with diagnoses of dementia, hypertension, and diabetes. Review of the resident's functional capacity screen dated 12-3-18 revealed the resident needed reminders to use his/her cane otherwise was independent with activities of daily living. The resident also could not manage his her own medications and needed supervision with medical treatments. The resident also had a cognitive deficit. Review of the resident's negotiated service agreement dated 12-3-18 revealed staff provided reminders and cues for the resident and staff administered all medications except they assisted the resident with accuchecks and supervised the resident's self injection of insulin. Staff would dial the pen to the proper dosage and then the resident would self-inject the insulin.	S3092		

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 _____	06/20/2019

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
S3092	Continued From page 3 Review of the residents record revealed he/she started home health services on 1-8-19. - Review of resident #124's medical record revealed he/she admitted to the facility on 12-4-17 with diagnoses of diabetes, hypertension and peptic ulcer disease. Review of the functional capacity screen dated 8-13-18 revealed the resident needed supervision with bathing and physical assistance with management of medications. Review of the negotiated service agreement dated 1-7-19 revealed staff prepared and assisted as needed with bathing and managed the resident's medications. It also identified the resident self injected insulin 4 times a day with staff assisting with preparing the insulin pen. Review of the residents record revealed the resident started home health services on 5-24-19. During an interview on 6-18-19 at 10:20 AM certified staff C reported the facility staff used to help residents with their insulin but a local home health agency comes in and administers the insulin now. During an interview on 6-19-19 aat 1:52 PM licensed nursing staff A reported the nurse should have done an addendum to the negotiated service agreement when resident #119 and #124 started using home health service to indicate what services they provided including the management of the residents accuchecks and administration of insulin. The operator failed to ensure designated staff	S3092		

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 _____	06/20/2019

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
S3092	Continued From page 4 reviewed and revised the negotiated service agreement for 2 residents after having a significant change in service needs.	S3092		
S3155 SS=D	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 26 residents. The sample included 3 residents. Based on observations, interview and record review, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of 1 (#111) of 3 residents related to safety assessment and use of a bed cane. Findings included: - Review of resident #111's medical record revealed he/she admitted to the facility on 5-20-19 with diagnoses of diabetes, obesity, hypertension and history of breast cancer.	S3155		

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 _____	06/20/2019

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
S3155	Continued From page 5 Review of the admission functional capacity screen (FCS) revealed the facility failed to complete a FCS. Review of the negotiated service agreement dated 5-20-19 revealed the resident needed stand by assistance with bathing and used a 4 wheeled walker as an assistive devise for walking. Observation on 6-19-19 at 10:18 PM revealed the resident had a bed cane on the right side of his/her bed that had the shape of an upside down U. It had a mesh divider between the two bars that was toward the lower end of the bed. The gap above the divide measured greater than 4 3/4 inches. Review of the medical record lacked an assessment to ensure the residents ability to safely use the cane as well as the safety of the cane including gaps which could lead to entrapment. 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 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.	S3155		

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 _____	06/20/2019

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
S3155	Continued From page 6 During an interview on 6-19-19 at 2:05 PM the resident reported he/she had used the rail while he/she lived at home and used it to pull him/herself over into the middle of the bed. During an interview on 6-19-19 at 1:49 PM licensed nursing staff reported the facility did not do assessments on bed rails or bed canes and the only type that were approved were the small circular ones. The operator failed to ensure a licensed nurse provided or coordinated a safety assessment for a resident who used bed rails a bed cane.	S3155		
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 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	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 _____	06/20/2019

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 by: KAR 26-41-205(a)(1) The facility reported a census of 26 residents. The sample included 3 residents. Based on record review and interview the operator failed to ensure designated staff completed a self-administration medication assessment before 3 (#111,#119. #124) of 3 residents began to self administer medications or self-manage medications that were prefilled by a licensed nurse to determine that the resident could perform the function safely and accurately without staff assistance. Findings included: - Review of resident #111's medical record revealed he/she admitted to the facility on 5-20-19 with diagnoses of diabetes, obesity, hypertension and history of breast cancer. Review of the admission functional capacity screen (FCS) revealed the facility failed to complete a FCS. Review of the negotiated service agreement dated 5-20-19 revealed the resident needed stand by assistance with bathing, used a 4 wheeled walker as an assistive devise for walking and administered his/her own medications except for his/her eye drops. Review of the residents record included a blank self -administration of medication assessment. - Review of residents #119's medical record revealed he/she admitted to the facility on 10-15-18 with diagnoses of dementia, hypertension, and diabetes.	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 _____	06/20/2019

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 Review of the resident's functional capacity screen dated 12-3-18 revealed the resident was independent with activities of daily living and could not manage his her own medications and needed supervision with medical treatments. Review of the resident's negotiated service agreement dated 12-3-18 revealed staff provided reminders and cues for the resident and staff administered medications except for assisting with accuchecks and supervised the resident's self injection of insulin. Review of the residents record lacked an assessment by a licensed nurse to determine the residents ability to safely and accurately self-inject his/her insulin. On 6-19-19 at 10:40 AM licensed nursing staff provided an undated self administration assessment which indicated the resident could not manage his/her own medications and did not address the resident's ability to safely and accurately self-inject his/her insulin. - Review of resident #124's medical record revealed he/she admitted to the facility on 12-4-17 with diagnoses of diabetes, hypertension and peptic ulcer disease. Review of the functional capacity screen dated 8-13-18 revealed the resident needed physical assistance with management of medications. Review of the negotiated service agreement dated 1-7-19 revealed staff prepared and assisted as needed with bathing and managed the resident's medications. It also identified the resident self injected insulin 4 times a day with	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 _____	06/20/2019

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 9 staff assisting with preparing the insulin pen. Review of the residents record lacked an assessment by a licensed nurse to determine the residents ability to safely and accurately self-inject his/her insulin. During an interview on 6-19-19 at 1:52 AM licensed nursing staff confirmed self administration assessment for resident #111 had not been completed and the facility did not do any type of assessment to ensure resident #119 and #124 could safely and accurately self-inject his/her insulin. The administrator failed to ensure designated staff completed a self-administration/self management assessment for residents #111, #119, and #124 to ensure they could safely and accurately self-administer or self- inject medications.	S3175		
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.	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 _____	06/20/2019

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 10 This REQUIREMENT is not met as evidenced by: KAR 26-41-105(a) The facility reported a census of 26 residents. The sample included 3 resident. Based on record review and interview the facility failed to ensure the maintenance of 3(#111, #119, #124) of 3 medical records in accordance with acceptable standards and practices. Findings included: - Review of resident #111's medical record revealed he/she admitted to the facility on 5-20-19 with diagnoses of diabetes, obesity, hypertension and history of breast cancer. Review of the admission functional capacity screen (FCS) revealed the facility failed to complete a FCS. Review of the negotiated service agreement dated 5-20-19 revealed the resident needed stand by assistance with bathing, used a 4 wheeled walker as an assistive devise for walking and administered his/her own medications except for his/her eye drops. Review of the nurses notes revealed multiple entries that did not include the time of the entry. - Review of residents #119's medical record revealed he/she admitted to the facility on 10-15-18 with diagnoses of dementia, hypertension, and diabetes.	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 _____	06/20/2019

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 11 Review of the resident's functional capacity screen dated 12-3-18 revealed the resident needed reminders to use his/her cane otherwise was independent with activities of daily living. Review of the resident's negotiated service agreement dated 12-3-18 revealed staff provided reminders and cues for the resident and staff administered medications except they assisted with accuchecks and supervised the resident's self injection of insulin. Review of the resident's nurses notes included multiple entries that included a date but not a time of the entry. It also included 3 pages with over half of the page blank and another page with space at the bottom of the page without an "X" or marked through, allowing the potential for someone to document in those open spaces. - Review of resident #124's medical record revealed he/she admitted to the facility on 12-4-17 with diagnoses of diabetis, hypertension and peptic ulcer disease. Review of the functional capacity screen dated 8-13-18 revealed the resident needed supervision with bathing and physical assistance with management of medications. Review of the negotiated service agreement dated 1-7-19 revealed staff prepared and assisted as needed with bathing and managed the resident's medications. IT also identified the resident self injected insulin 4 times a day with staff assisting with preparing the insulin pen. Review of the nurses notes included multiple entries that included a date but not a time of the	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 _____	06/20/2019

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 12 entry. It also revealed 4 pages of notes with large areas without any documentation or an "X" marked through to prevent someone else from adding documentation. The operator failed to ensure resident records were maintained according to acceptable standards of practice.	S3250		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 26 residents. The sample included 3 residents. Based on record review and interview for 3(#111, #119, #124) of 3 residents sampled, the operator failed to ensure the resident's record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. Findings included: - Review of resident #111's medical record revealed he/she admitted to the facility on 5-20-19 with diagnoses of diabetes, obesity,	S3261		

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 _____	06/20/2019

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
S3261	Continued From page 13	S3261		

hypertension and history of breast cancer.

Review of the admission functional capacity screen (FCS) revealed the facility failed to complete a FCS.

Review of the negotiated service agreement dated 5-20-19 revealed the resident needed stand by assistance with bathing, used a 4 wheeled walker as an assistive devise for walking and administered his/her own medications except for his/her eye drops.

Review of the nurses notes revealed the first entry was 6-7-19, 18 days after admission to the facility and did not include information that he/she moved into the facility or any specific needs the resident had.

During an interview on 6 -19-18 at 3:45 PM administrative staff A reported the resident moved into the facility and the next day he/she had cataract surgery. Then 2 days later the resident went into the hospital to have another surgery and then returned a few days later.

The record also included local home health notes which mentioned treatment of 2 pressure ulcers to the resident's coccyx area.

The record lacked any of the above information regarding the resident's surgeries or the resident's pressure ulcers.

During an interview on 6-19-19 at 3:35 PM licensed nursing staff confirmed that record should have included information regarding the residents admission to the facility and surgeries should have been included in the nurses notes.

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 _____	06/20/2019

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
S3261	Continued From page 14 - Review of residents #119's medical record revealed he/she admitted to the facility on 10-15-18 with diagnoses of dementia, hypertension, and diabetes. Review of the resident's functional capacity screen dated 12-3-18 revealed the resident needed reminders to use his/her cane otherwise was independent with activities of daily living. Review of the resident's negotiated service agreement dated 12-3-18 revealed staff provided reminders and cues for the resident and staff administered medications except they assisted with accuchecks and supervised the resident's self injection of insulin. Review of the resident's nurses notes revealed on 3-15-19 the resident had nausea/vomiting and diarrhea. The resident's family took the resident to the emergency department for evaluation and the resident was admitted to the hospital. The resident's nurses notes lacked documentation regarding the residents return to the facility or follow up related to diagnosis of c-difficile at the hospital. During an interview on 6-19-19 at 9:20 AM licensed nursing staff B confirmed the record should have included documentation of the residents return from the hospital status/post admission for c-difficile. - Review of resident #124's medical record revealed he/she admitted to the facility on 12-4-17 with diagnoses of diabetes, hypertension and peptic ulcer disease. Review of the functional capacity screen dated	S3261		

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 _____	06/20/2019

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
S3261	Continued From page 15 8-13-18 revealed the resident needed supervision with bathing and physical assistance with management of medications. Review of the negotiated service agreement dated 1-7-19 revealed staff prepared and assisted as needed with bathing and managed the resident's medications. It also identified the resident self injected insulin 4 times a day with staff assisting with preparing the insulin pen. Review of the fall investigation revealed the resident had 3 falls and an episode of choking which required the nurse to perform the Heimlich maneuver from 1-10-19 to 1-30-19. Review of the nurse's notes included the above incidents except for the fall that occurred on 1-10-19 where the resident walked to lunch and his/her leg gave out and he/she had an unwitnessed fall. During an interview on 6-19-19 at 1:52 PM licensed nursing staff B reported the residents fall should have been included in the nurse's notes. The operator failed to ensure the resident's records contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.	S3261		
S3310 SS=E	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	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 _____	06/20/2019

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 infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: K.A.R 26-207(c) The facility reported a census of 26 residents. The sample included 3 residents. Based on interview and record review for 2 (#111 and #119) of 3 residents, the operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This failure effected all residents who lived in the residential health care facility. Findings included: - Review of resident #111's medical record revealed he/she admitted to the facility on 5-20-19 with diagnoses of diabetes, obesity, hypertension and history of breast cancer. Review of the resident's record lacked evidence the facility administered a 2-step tuberculosis (TB) skin test upon admission. - Review of residents #119's medical record revealed he/she admitted to the facility on	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 _____	06/20/2019

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 10-15-18 with diagnoses of dementia, hypertension, and diabetes. Review of the record lacked revealed staff completed a TB questionnaire on 10-15-18 but lacked evidence the facility administered a 2-step tuberculosis (TB) skin test upon admission. For 2 (#111 and #119) of 3 residents the operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		