| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| COUNTRY PLACE SENIOR LIVING OF CHANUTE | 701 OSA MARTIN BLVD CHANUTE, KS 66720 |

| (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 |
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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of the licensure resurvey for the above named facility conducted on 2/27/19, 2/28/19 and 3/4/19. | S 000 | | |
| S3155 SS=E | 26-41-204 (a) Health Care Services<br><br>. (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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41 204 (a)<br><br>The facility reported a census of 29 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs for 3 of 3 sampled residents (#227, #289 and #318) regarding staff assistance to transfer and use of bed assistive devices/rails.<br><br>Findings included:<br><br>- Record review for resident #227 revealed an admission date of 6/1/16 with diagnoses of Parkinson's, anemia and hyperlipidemia. | S3155 | | |

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

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| S3155 | Continued From page 1<br><br>The significant change functional capacity screening (FCS) dated 8/16/18 identified the resident with short-term and long-term cognitive deficit, impaired memory recall and decision making. He/she required physical assistance with transfer, walking/mobility and eating and was unable to perform bathing, dressing, toileting needs or manage his/her own medications and treatments. The FCS indicated the resident used assistive device which included a wheelchair and a cane/walker/crutch (did not indicate which). He/she was at risk for falls and /or unsteadiness with impaired vision and hearing.<br><br>The negotiated service agreement/health service plan (NSA/HSP) dated 8/16/18 directed staff to provide total assistance with bathing, hygiene, dressing and toileting. Under the section for transfers - resident required staff assistance with transfers, required simple directions/commands "nose over toes" which reminded the resident to look at his/her toes to lean forward when standing. Staff should place a hand behind the resident's back for guidance. He/she needed encouragement to have one hand on the walker and one hand on the chair to help push him/herself up. Staff should use a gait belt. The NSA/HSP was amended in the fall prevention portion on 9/15/18 with education of staff and family about placement of a personal body alarm to alert staff of resident's movements. On 10/25/18 regarding a change in hospice providers and on 11/26/18 for staff to offer hourly toileting at bedtime and a snack.<br><br>Review of the nursing notes revealed an entry dated 12/31/18 at 12:15 PM resident continues to require staff assistance to transfer to wheelchair. He/she used a wheelchair for mobility and cannot self-propel. On 1/31/19 at 10:45 AM resident | S3155 | | |

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| S3155 | Continued From page 2<br>continues to require assistance with all activities of daily living (ADLs). He/she needed assistance with transfers, mobility and had no significant changes. The note failed to indicate how many staff were needed to transfer the resident.<br><br>Observation on 2/27/19 at 3:05 PM revealed certified nursing staff C and D applied a gait belt to the resident's torso and with the assistance of both staff assisted the resident to stand and transfer from the wheelchair to an easy chair in the lobby. On 2/28/19 at 11:14 AM certified nursing staff D and E used a gait belt and both staff assisted the resident to stand from the wheelchair, take a few steps and pivot transfer to the toilet. The resident was able to follow directions with hand over hand guidance to use the grab bars.<br><br>Interview on 2/18/19 at 11:14 AM with certified nursing staff D confirmed the resident needed 2 staff to transfer for safety.<br><br>Interview on 2/18/19 at 9:40 AM with licensed nurse F indicated the resident needed 1 or 2 staff for assistance to transfer depending on the day, time and his/her abilities. Licensed nurse F confirmed the NSA/HSP did not direct staff on when to use 1 staff or 2 staff while assisting the resident to transfer.<br><br>The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident regarding the amount of staff needed for transferring between surfaces.<br><br>- Record review for resident #318 revealed an admission date of 9/08/16 with diagnoses of chronic renal insufficiency and diabetes. | S3155 | | |

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| S3155 | Continued From page 3<br><br>The semi-annual functional capacity screen (FCS) dated 1/23/19 identified the resident with short-term memory deficit and independent with transfers/mobility and toileting. The FCS indicated the resident used an assistive device of cane/walker or crutch but did not specify which. He/she was not identified with unsteadiness or at risk for falls.<br><br>The negotiated service agreement/health service plan (NSA/HSP) dated 1/23/19 directed staff to provide physical assistance with bathing and dressing for application of compression stockings but otherwise the resident was independent with activities of daily living. The resident used a walker for mobility. The NSA/HSP did not include any other assistive device.<br><br>The record included a side rail assessment dated 12/21/18 which indicated the resident used side rails as an enabler to promote independence and the resident expressed a desire to have side rails raised while in bed. The assessment failed to indicate the bed assistive device design/attachment/gaps and mechanisms were safe.<br><br>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:<br>Zone 1 within the rail should measure less than 4 and 3/4 inches<br>Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches<br>Zone 3 between the rail and the mattress should | S3155 | | |

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| S3155 | Continued From page 4 | S3155 | | |

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.

Observation on 2/27/19 at 4:00 PM revealed the resident's bed was against the wall on 1 side and had a quarter bed rail in the upright position. The open side of the bed also had quarter bed rail which was in the down position. The gaps between each bar of the bed rail measured about 5 inches, the gap between the rail and the mattress was less than 2 and 3/8 inches. The bed rail was securely attached to the bed.

Interview on 2/27/19 at 4:00 PM with the resident confirmed the bed always had the bed rail attached. He/she indicated the outer rail was never in the upright position and he/she did not use the rails to get in/out of the bed or to turn over in the bed.

Interview on 2/28/19 at 12:40 PM with licensed nurse F confirmed the NSA/HSP lacked information about the bed rails attached to the resident's bed.

The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident regarding use of a bed assistive device/bed rail.

- Record review for resident #289 revealed an admission dated of 5/11/17 with diagnoses of weakness, failure to thrive and disturbance suspect related to spinal cord injury of undetermined type.

The semi-annual functional capacity screen (FCS) dated 1/10/19 indicated the resident had

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| S3155 | Continued From page 5<br>short-term and long-term memory deficit, impaired memory recall and decision making. He/she needed physical assistance with all activities of daily living. He/she was at risk for falls or had unsteadiness, used a wheelchair and an assistive device cane/walker/crutch (did not specify which).<br><br>The negotiated service agreement/health service plan (NSA/HSP) dated 1/10/19 directed staff to provide physical assistance with bathing, dressing, transfers/mobility and toileting. Staff to use a gait belt and walker when assisting the resident to transfer. The resident used a hospital style bed with bilateral bed rails for positioning.<br><br>The current notebook record for the resident lacked a bed rail use assessment. Licensed nurse F retrieved an assessment from the medical record overflow dated 5/11/18. The top portion of the assessment with the questions to determine the resident's ability and safety was not completed. Under interventions licensed nurse F marked provide frequent staff monitoring at night, provide assisted toileting to resident at night with visual and verbal reminders to use the call bell. The recommendations were for bilateral bed rails because the resident expressed a desire to have the bed rails raised while in bed.<br><br>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:<br>Zone 1 within the rail should measure less than 4 and 3/4 inches<br>Zone 2 under the rail, between the rail supports or next to a single rail support should measure | S3155 | | |

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| S3155 | Continued From page 6<br>less than 4 and ¾ inches<br>Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches<br>Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches.<br><br>Observation on 2/28/19 at 9:25 AM revealed the resident had quarter bed rails on both sides of the bed with 1 side raised. The rails were securely attached to the bed and measured about 5 inches between each bar on the rail and less than 2 and 3/8 inches between the rail and the mattress.<br><br>Interview on 2/28/19 at 12:40 PM with licensed nurse F confirmed the bed rail use assessment was not complete for the assessment component and lacked safety measurements.<br><br>The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident regarding the use of bed rails. | S3155 | | |
| S3200 SS=E | 26-41-205 (d) (1-2) Facility Administration of Medications<br><br>(d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met:<br>(1) Only licensed nurses and medication aides shall administer and manage medications for | S3200 | | |

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| S3200 | Continued From page 7<br>which the facility has responsibility.<br>(2) Medication aides shall not administer medication through the parenteral route.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-205 (d) (1)<br><br>The facility reported a census of 29 residents. The sample included 3 residents. Based on record review and interview the operator failed to ensure that all medications and biologicals were administered to each resident which the facility managed in accordance with a medical care provider's written order for 3 of 3 sampled residents (#227, #289 and #318).<br><br>Findings included:<br><br>- Record review for resident #227 revealed an admission date of 6/1/16 with diagnoses of Parkinson's, anemia and hyperlipidemia.<br><br>The significant change functional capacity screening (FCS) dated 8/16/18 identified the resident with short-term and long-term cognitive deficit, impaired memory recall and decision making. He/she required physical assistance with transfer, walking/mobility and eating and was unable to perform bathing, dressing, toileting needs or manage his/her own medications and treatments.<br><br>The negotiated service agreement/health service plan (NSA/HSP) dated 8/16/18 directed staff to administer the resident's medications as order by | S3200 | | |

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| S3200 | Continued From page 8<br>the physician.<br><br>Record review of the last signed recapitulation of the physician orders dated 10/24/18 and compared to the February 2019 medication administration record (MAR) revealed no physician order for the following medications: multivitamin with minerals 1 daily and Lorazepam 0.5 milligrams 1 or 2 tablets every 4 hours as needed.<br><br>The February 2019 MAR included daily initials for the multivitamin administration.<br><br>Interview with licensed nurse F on 2/28/19 at 9:20 AM confirmed the record and physician's orders lacked orders for the multivitamin and the Lorazepam.<br><br>The operator failed to ensure that all medications and biologicals were administered to this resident in accordance with a medical care provider's written order.<br><br>- Record review for resident #289 revealed an admission dated of 5/11/17 with diagnoses of weakness, failure to thrive and disturbance suspect related to spinal cord injury of undetermined type.<br><br>The semi-annual functional capacity screen (FCS) dated 1/10/19 indicated the resident had short-term and long-term memory deficit, impaired memory recall and decision making. He/she needed physical assistance with all activities of daily living. He/she was unable to manage his/her own medications.<br><br>The negotiated service agreement/health service plan (NSA/HSP) dated 1/10/19 directed staff to | S3200 | | |

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| S3200 | Continued From page 9<br>administer the resident's medication per physician's order.<br><br>Review of a detailed physician visit note which included a current medications list and signed by the physician on 2/15/19, compared to visit notes also with medication orders dated 2/18/19 and another visit on 2/26/19 revealed the following discrepancies:<br>On 2/15/19 Amlodipine 2.5 milligrams (mg) 1 tablet twice a day then on 2/18/19 Amlodipine 2.5 mg once a day and on 2/26/19 for once a day<br>On 2/15/19 Lisinopril 10 mg 1.5 tablets twice a day, then on 2/18/19 Lisinopril 10 mg 1.5 tablets once a day and on 2/26/19 for once a day.<br>The following orders appeared on the 2/15/19 orders but not the 2/18/19 or 2/26/19 orders: Aquaphor topically twice a day, Eucerin cream topically twice a day, Lomotil 2.5 mg 1 three times a day PRN (as needed), zinc oxide to affected area PRN and Calmoseptine to affected area PRN.<br><br>All 3 of the physician visit notes with orders were noted by licensed nurse F.<br><br>Review of the February 2019 medication administration record revealed from 2/1/19 through a.m. of 2/18/19 revealed staff initialed administration of Amlodipine 2.5 mg twice a day, Lisinopril 10 mg 1.5 tablets twice a day, Eucerin cream daily and Aquaphor lotion daily.<br><br>Interview on 2/28/19 at 9:55 AM with licensed nurse F confirmed when a nurse noted a physician order or progress note/visit he/she signified comparing the orders for accuracy and would need to contact the physician for discrepancies. He/she reviewed the resident's record and confirmed the above discrepancies | S3200 | | |

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| S3200 | Continued From page 10<br>and administrations of medications.<br><br>The operator failed to ensure that all medications and biologicals were administered to this resident in accordance with a medical care provider's written order.<br><br>- Record review for resident #318 revealed an admission date of 9/08/16 with diagnoses of chronic renal insufficiency and diabetes.<br><br>The semi-annual functional capacity screen (FCS) dated 1/23/19 identified the resident with short-term memory deficit and independent with transfers/mobility and toileting. The FCS indicated the needed physical assistance with medications and treatments.<br><br>The negotiated service agreement/health service plan (NSA/HSP) dated 1/23/19 directed staff to provide administer medications as ordered by the physician<br><br>Review of the physician orders revealed a signed order dated 1/21/19 to decrease Cardura to 2 milligrams (mg) daily. Review of the February 2019 medication administration record (MAR) staff initialed administration daily of Cardura 4 mg between 2/01/19 and 2/26/19.<br><br>Review of the recapitulation of orders signed 1/21/19 revealed order for Ocusoft Hypochlor external gel (eyelid cleansers) apply at HS (bedtime). Review of February 2019 MAR Ocusoft Hyprochler spray on to cotton swab and apply to eyelids and eyelashes of both eyes twice daily. The MAR had initials of staff to indicate administration twice a day between 2/01/19 and 2/26/19. | S3200 | | |

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| S3200 | Continued From page 11<br>Interview on 2/27/19 at 4:20 PM with licensed nurse F confirmed the above medications were administered incorrectly and without a physician's order.<br><br>The operator failed to ensure that all medications and biologicals were administered to this resident in accordance with a medical care provider's written order. | S3200 | | |
| S3202 SS=E | 26-41-205 (d) (4) Delegation of Medication Administration<br><br>(4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-205 (d) (4)<br><br>The facility reported a census of 29 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to ensure a licensed nurse oriented and instructed certified medication aides (CMA) G and H in the performance of blood sugar testing, dialing a dose of insulin by insulin pen and further failed to document a demonstration of the staff's competency signed by the nurse and the CMA in each person's personnel record.<br><br>Findings included:<br><br>- On 2/27/19 at 2:00 PM licensed nurse/operator | S3202 | | |

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| S3202 | Continued From page 12<br>A reported certified medication aides (CMAs) were delegated to perform blood sugar testing and dose dialing of the insulin pens.<br><br>Review of the personnel file for CMA G on 2/28/19 revealed he/she began employment on 9/27/18. The record lacked documentation of additional training to allow this CMA to perform blood sugar testing or dose dialing of insulin pens.<br><br>Review of the personnel file for CMA H revealed he/she began employment on 2/07/19. The record lacked documentation of additional training to allow this CMA to perform blood sugar testing or dose dialing of insulin pens.<br><br>Interview on 2/28/19 at 11:55 AM with licensed nurse F confirmed all the CMAs employed by the facility were expected to perform blood sugar testing on residents and would dial the dose on the insulin pen for the resident to inject. He/she confirmed none of the CMAs had documentation of the further training/competency to allow them to perform blood sugar testing and insulin pen dose dialing.<br><br>The facility failed to have evidence of additional training for certified medication aides to ensure the CMAs were competent and safe with duties delegated regarding blood sugar testing and dosing of insulin pens. | S3202 | | |
| S3211 SS=E | 26-41-205 (g) (3) OVER THE COUNTER DRUGS<br><br>(3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A | S3211 | | |

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| S3211 | Continued From page 13<br>licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-205 (g)(3)<br><br>The facility reported a census of 29 residents. The facility reported managing the medications for 26 of the 29 residents. Based on observation and interview the operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on the original manufacturer's package of over-the-counter medications. If the original manufacturer's package contains a container, bottle or tube which can be removed from the original package then both must be labeled with the resident's full name.<br><br>Findings included:<br><br>- On 2/27/19 at 2:11 PM certified medication aide (CMA) C opened the locked medication storage room cabinets. Observation revealed baskets of unit dose prescription medications and bottles/tubes/containers of over-the-counter (OTC) medications. The following OTC medications lacked proper labeling with the resident's full name: | S3211 | | |

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| S3211 | Continued From page 14<br><br>Resident #318 had 1 OTC bottle with no name and CMA C identified as belonging to resident #318<br>Resident #423 had a labeled box of eye drops with his/her full name. The box had 2 containers of the eye drops inside and the containers were not labeled at all. He/she also had a bottle of stool softener not labeled at all.<br>Resident #289 had 2 boxes of artificial tears. One box had the resident's name on it but the other did not. Within the open box was a bottle of the artificial tears with no identification.<br>Resident #462 had 2 OTC bottles with 1 having his/her first name written on it and the other had no identification<br>Resident #471 had 2 bottles of OTC lubricating eye drops loose in his/her designated basket with no identification. CMA C identified them as belonging to resident #471.<br>Resident #488 had a box of eye drops labeled with his/her name but the bottle inside the box had no identification<br>Resident #512 had 1 bottle of OTC medication which had his/her first name written on it.<br><br>On a shelf under the cabinets were other medications and OTC medications which CMA C reported was overflow medications for the residents. On the shelf were the following OTC medications without any identification and CMA C could not identify which resident the medication belonged to:<br>Aspirin 325 milligrams (mg)<br>Box of allergy relief OTC<br>Box of mucous relief which CMA C thought belonged to resident #601.<br>A box of OTC heartburn relief with resident #543's first name and the bottle inside had the residents first name written on it. The shelf also had a box of digestive aide labeled with resident | S3211 | | |

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| S3211 | Continued From page 15<br>#543's first initial and last name.<br><br>Interview on 2/27/19 at 2:11 PM with CMA C revealed when the resident or the family brings in OTC medications either the family or resident would write the resident's name on the bottle or the CMA would write it on there and then date it when opened.<br><br>Interview on 2/27/19 at 2:45 PM with licensed nurse F confirmed the facility CMAs would label the bottles of OTC medications which family provided, and the staff had designated white labels to use. He/she was not aware the OTC medications were required to be labeled by a licensed nurse or licensed pharmacist.<br><br>The operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on the original manufacturer's package of over-the-counter medications. If the original manufacturer's package contains a container, bottle or tube which can be removed from the original package then both must be labeled with the resident's full name. | S3211 | | |
| S3213 SS=D | 26-41-205 (g) (2) Medication Labeling<br><br>(g) (2) Each prescription medication container shall have a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14.<br><br>This REQUIREMENT is not met as evidenced by: | S3213 | | |

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| S3213 | Continued From page 16<br>KAR 26-41-205 (g)(2)<br><br>The facility reported a census of 29 residents. Based on observation and interview the operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist for resident #322.<br><br>Findings included:<br><br>- On 2/27/19 at 2:11 PM certified medication aide (CMA) C opened the locked medication storage room cabinets. Observation revealed on a top shelf of 1 cabinet sat 2 white boxes of prescription medication albuterol/ipratropium (DuoNeb) for inhalation by nebulizer. One of the boxes had resident #322's name handwritten on it and the other had no identification. Neither box had a pharmacy label.<br><br>Interview on 1/27/19 at 2:11 PM with CMA C revealed the medication usually comes 3 boxes at a time and 1 of the boxes will have the pharmacy label on it and he/she would write the resident's name on the other boxes. He/she was not sure if the unidentified box belonged to resident #322 or resident #323 who also received the same medication.<br><br>Interview on 1/27/19 at 2:25 PM with licensed nurse F confirmed the prescription medication should have a label from the pharmacy on them.<br><br>The operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist for this resident. | S3213 | | |

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| S3248 | Continued From page 17 | S3248 | | |
| S3248 SS=F | 26-41-102 (d) Staff Qualifications Employee Records<br><br>(d) The employee records and agency staff records shall contain the following documentation:<br>(1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training;<br>(2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto;<br>(3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and<br>(4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-102 (d)(1)(3)<br><br>The facility reported a census of 29 residents. Based on interview and record review the facility failed to have evidence they verified the nursing license for licensed nurse/operator A at the time of employment. The facility also failed to check | S3248 | | |

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| S3248 | Continued From page 18<br>with the nurse aide registry for 1 of 3 certified nurse aides/certified medication aides hired since last resurvey (nurse aide G). Both employees had the potential to provide care to all the residents.<br><br>Findings included:<br><br>- Personnel record review on 2/28/19 at 11:25 AM revealed licensed nurse/operator A began employment on 10/01/18. The record included verification of his/her operator license but failed to include verification of his/her nursing license.<br><br>Review of the personnel record for certified nursing assistant G revealed he/she began employment on 9/27/18. The personnel file lacked registry verification.<br><br>Licensed nurse/operator A confirmed the record lacked evidence of the nursing license verification and the nurse aide registry verification for CNA G. He/she called the corporate office and confirmed the records there failed to have the verification of his/her nursing license on file or the registry verification for CNA G.<br><br>The facility failed to have evidence they verified the nursing license for licensed nurse/operator A and registry verification for CNA G. Both employees had the potential to provide care to all the residents. | S3248 | | |
| S3280 SS=E | 26-41-104 (d) Disaster and Emergency Preparedness<br><br>(d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: | S3280 | | |

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| S3280 | Continued From page 19<br>(1) Orientation of new employees at the time of employment to the facility ' s emergency management plan;<br>(2) education of each resident upon admission to the facility regarding emergency procedures;<br>(3) quarterly review of the facility ' s emergency management plan with employees and residents; and<br>(4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-104 (d) (3)<br><br>The facility reported a census of 29 residents. Based on interview and record review the operator failed to ensure the residents and staff had disaster and emergency preparedness by a failure to conduct a quarterly review of the facility's emergency management plan.<br><br>Findings included:<br><br>- On 2/28/19 at 10:00 AM licensed nurse/operator A provided file folders of documents for the emergency preparedness review with residents. The file folders held disorganized documents some for another facility and some for this facility. Sorting of the documents revealed 8 pages without a date at all or it just had the month or just the year, 2 sheets dated 12/6 but no year and in right corner was handwritten Jan 2018. The June 2018 signature | S3280 | | |

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| S3280 | Continued From page 20 | S3280 | | |

sheets did not identify what topics were covered. There were 2 sheets with some of the same resident names dated Dec 18/Jan 19 and the 2 sheets listed different topics so that it was unclear if the entire facility emergency management plan was reviewed.

On 2/28/19 at 10:40 AM licensed nurse/operator A provided a notebook for the documentation of staff training/review for emergency preparedness. Review of the notebook revealed monthly divider tabs with signature page and emergency topics as follows:
1/24/18 - fire, flood, weather
None for February 2018
3/29/18 - evacuation and bomb threats
None for April 2018
5/24/18 was not clearly marked with preprinted topics as previous months
The June 2018 slot was blank
7/23/18 review of the emergency and disaster procedures
8/2/18 review of the emergency and disaster procedures
9/26/18 elopement prevention, fire prevention and safety

The 1/24/19 signature page for in-service topic was blank

Upon request licensed nurse/operator A confirmed he/she failed to have evidence of disaster and emergency preparedness quarterly review with all residents and staff to cover all 9 elements of disaster and emergency preparedness as required (fire, flood, severe weather, tornado, explosion, natural gas leak, lack of electrical or water service, missing resident and any other potential emergency situations) at least every quarter.

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| S3280 | Continued From page 21<br><br>The operator failed to ensure the residents and staff had disaster and emergency preparedness by a failure to provide information on the facility's emergency plan at the time of admission, time of employment and conduct a quarterly review of the facility's emergency management plan. | S3280 | | |