STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N098002	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREGO LEMKE ASSISTED LIVING	303 N 14TH ST WA KEENEY, KS 67672

(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 9/10,11/2018.	S 000		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a) The facility reported a census of 2 residents. The sample included both residents. Based on record review and interview the operator failed to ensure on or before admission designated staff completed a screening to determine the residents functional capacity and record all findings on a screening form as specified by the department. Findings included: - Record review for Resident #910 revealed an	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
	N098002	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREGO LEMKE ASSISTED LIVING	303 N 14TH ST WA KEENEY, KS 67672

(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 admission date of 6/2/18 with diagnoses of dementia, osteoporosis, anxiety disorder and reflux disease. The functional capacity screen had a date of 6/4/18 , 2 days after admission to the facility. During an interview on 9/10/18 at 1:56 PM administrative staff A reported he/she went out and "screened" the resident prior to admission on 5/15/18. Staff A showed the screen form used and it only included basic Activities of daily living screening and not all of the information as specified by the department. The resident moved in on a Saturday and staff A said she then completed the functional capacity screen that next Monday. The operator failed to ensure designated staff completed the functional capacity screening on or before admission.	S3080		
S3090 SS=F	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-41-212(c) The facility reported a census of 2 residents. The sample included both residents. Based on observation and interview for the operator failed	S3090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N098002	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREGO LEMKE ASSISTED LIVING	303 N 14TH ST WA KEENEY, KS 67672

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3090	Continued From page 2	S3090		

to ensure the development of an initial negotiated service agreement at admission for both residents.

Findings included:

- Record review for Resident #910 revealed an admission date of 6/2/18 with diagnoses of dementia, osteoporosis, anxiety disorder and reflux disease.

The functional capacity screen dated 6/4/18 revealed the resident needed supervision with bathing, physical assistance with medication management, had occasional bladder incontinence, and had impaired vision and hearing..

Review of the negotiated service agreement had a date of 6/20/18, 18 days after admission.

During an interview on 9/10/18 at 1:56 PM administrative staff A reported the resident admitted to the facility on a Saturday and he/she did not feel the negotiated service agreement captured everything until the 20th and had family sign it then.

- Review of resident #911 revealed he/she admitted to the facility on 8/25;/17 with diagnoses of congestive heart failure, coronary artery disease, hypertension, cataracts and osteoporosis.

Review of the admission functional capacity screen dated 8/25/17 revealed the resident was independent in ADLs including medication management but had falls/unsteadiness, impaired vision and hearing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N098002	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREGO LEMKE ASSISTED LIVING	303 N 14TH ST WA KEENEY, KS 67672

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3090	Continued From page 3 Review of the negotiated service agreement had a date of 9/11/17, 16 days after admission. During an interview on 9/10/18 at 1:56 PM administrative staff A reported he/she started the negotiated service agreements on admission and as they get to know the residents he/she then completes it. The operator failed to ensure a negotiated service agreement was completed at admission for all residents.	S3090		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (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. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3)	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N098002	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREGO LEMKE ASSISTED LIVING	303 N 14TH ST WA KEENEY, KS 67672

(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
S3280	Continued From page 4 The facility reported a census of 2. The sample included both residents. Based on interview for all residents and all facility employees, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with employees and residents. Findings included: - During an interview on 9/10/18 at approximately 2:10 PM administrative staff A reported he/she had visited with residents during meals at different times the flip chart with emergency management plans but did not have an evidence of the review. Staff A reported he/she thought staff review was completed annually. For all residents and employees, the operator failed to ensure emergency preparedness by ensuring quarterly review of the emergency management plan with all staff and residents.	S3280		