STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N103004	A. BUILDING: _____ B. WING _____	09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF FREDONIA	2111 E WASHINGTON STREET FREDONIA, KS 66736

(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 of the above assisted living facility on 9/5/18, 9/11/18, 9/12/18, and 9/13/18.	S 000		
S3155 SS=E	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 28 residents. The sample included 3 residents and 1 focus review resident. Based on record review, observation, and interview for 2 (#400 and #200) of 3 residents sampled identified as at risk for falls and 2 (#400 and #300) of 2 residents sampled utilizing a bed rail, operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #400 revealed an	S3155		

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

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S3155	Continued From page 1 admission date of 10/23/17 with diagnoses of type 2 diabetes mellitus and dementia. Functional capacity screen dated 10/23/17 indicated resident was independent with transferring and mobility with walker or wheelchair; required physical assistance with bathing dressing, toileting, experienced impaired short-term memory, long-term memory, memory recall, and decision making; and was at risk for falls. Negotiated service agreement (NSA) and health care service plan (HCSP) dated 10/17/17 lacked interventions to address resident's risk for falls. Nurse's notes contained documentation that resident experienced falls: 11/16/17 Resident slid off bed when getting up from bed. 11/23/17 Resident lost balance when walking with walker. 12/4/17 Resident fell when trying to sit in wheelchair. 1/5/18 Resident got up to go to bathroom, lost balance and fell. 2/5/18 Resident slid out of recliner. Review of fall investigations completed after each fall included interventions of instruct resident on proper transfer, lock brakes on wheelchair before transferring, call for staff assistance, use walker when standing for stability, use wheelchair or walker for mobility, call staff to assist with toileting at night, and lower left chair as soon as seated. None of the interventions were listed in resident's NSA/HCSP. During an interview at 10:20 a.m. on 9/11/18, certified staff D stated fall interventions of walk	S3155		

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S3155	Continued From page 2	S3155		

with resident, provide toileting assistance, remind to use call light for assistance, and check on resident frequently.

During time in facility on 9/5/18, surveyor observed a small curved rail on side of resident's bed. Resident's NSA/HCSP did not describe resident's need for and use of a bed rail. Resident's record lacked an assessment of the safety of the bed rail and resident's ability to safely use the device.

During an interview at 10:47 a.m. on 9/11/18, licensed nurse C reviewed the residents' NSA and HCSP and confirmed each did not describe interventions to address resident's risk for falls. Licensed nurse C stated he/she was not aware resident had a bed rail and confirmed the lack of an assessment of the safety of the device and resident's ability to use safely. Licensed nurse C stated and confirmed the NSA/HCSP lacked a description of resident's need for and use of a bed rail.

During an interview at 12:45 p.m. on 9/11/18, resident stated he/she used the bed rail to get in and out of bed. Surveyor noted that rail appeared to be attached to the bed and did not move freely.

Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #400 and were in accordance with the functional capacity screening and the negotiated service agreement.

- Record review for resident #200 revealed an admission date of 6/1/18 with diagnoses of type 2 diabetes mellitus and chronic obstructive pulmonary disease.

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S3155	Continued From page 3 Functional capacity screen dated 8/21/18 indicated resident required physical assistance to bathe, dress, toilet, transfer, and walk; did not experience impaired cognition, and was at risk for falls. Negotiated service agreement (NSA) and health care service plan (HCSP) lacked interventions to address resident's risk for falls. Nurse's notes documented that on 8/22/18 2 staff were assisting resident to bedside commode when resident's knees buckled, and staff lowered resident to floor. Nurse's notes entry 8/26/18 that resident fell when 2 staff were walking with resident while using walker. Resident looked over shoulder and lost balance falling to left onto staff member. Written investigation of the 8/26/18 fall included intervention of instructed resident to not turn and look behind when walking forward. During an interview at 10:24 a.m. on 9/11/18, certified staff D stated resident reminded to call for assistance when needed. At 10:40 a.m. on 9/11/18, licensed nurse C confirmed resident had fallen and NSA/HCSP lacked interventions to address resident's risk for falls. Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #200 and were in accordance with the functional capacity screening and the negotiated service agreement.	S3155		

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S3155	Continued From page 4 - Record review for resident #300 revealed an admission date of 2/23/16 with diagnoses of Alzheimer's dementia and coronary disease. Functional capacity screen dated 7/20/18 indicated resident was independent with transferring and mobility with a walker and experienced impaired short-term memory, long-term memory, memory recall, and decision making. During time in facility on 9/5/18, surveyor observed a small curved bed rail on side of bed that was not snug against the side of the bed. Resident's negotiated service agreement and health care service plan each dated 7/20/18 did not describe resident's need for and use of a bed rail. Resident's record lacked an assessment of the safety of the bed rail and resident's ability to safely use the device. During an interview at 10:26 a.m. on 9/11/18, licensed nurse C stated the bed rail on resident's bed slid between mattress and box springs and was not attached to the bed. Licensed nurse C stated resident used the device to get in and out of bed. Licensed nurse C stated he/she did not assess the safety of the rail and resident's ability to safely use the rail. Licensed nurse C stated the NSA/HCSP did not describe resident's use of bed rail. At 12:57 p.m. on 9/11/18 surveyor interviewed resident in his/her room. Resident was resting in bed and bed rail was still pulled out to side of bed. Resident stated he/she did not know the purpose of the rail. Operator B failed to ensure a licensed nurse provided or coordinated the provision of	S3155		

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S3155	Continued From page 5 necessary health care services that met the needs of resident #300 and were in accordance with the functional capacity screening and the negotiated service agreement.	S3155		
S3166 SS=E	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(e) The facility reported a census of 28 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1 (#200) of 1 sampled resident and 1 (#500) of 1 focus review resident each requiring glucometer testing for blood sugar levels and 3 of 3 certified medication aide (CMA) employee files reviewed, operator B failed to ensure a licensed nurse delegated the nursing procedure of glucometer testing to each CMA under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included: - Record review for resident #200 revealed an admission date of 6/1/18 with diagnoses of type 2	S3166		

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S3166	Continued From page 6	S3166		

diabetes mellitus, chronic obstructive pulmonary disease, and hypertension.

Functional capacity screen dated 8/21/18 indicated resident required physical assistance with management of medications.

Negotiated service agreement dated 8/21/18 documented management of medication "Per nurse/CMA as ordered by physician."

Record contained hospital discharge orders dated 8/21/18 for resident to begin receiving Novolog insulin with dose determined by blood sugar readings. (Resident was not receiving insulin prior to hospitalization).

August 2018 and September 2018 medication administration records documented resident to receive glucometer testing 4 times a day to determine need for Novolog insulin.

- Record review for resident #500 revealed an admission date of 6/1/17 with diagnosis of type 2 diabetes mellitus.

Functional capacity screen dated 5/10/18 indicated resident required physical assistance with medication management.

Negotiated service agreement dated 5/10/18 documented medication management "Per nurse/CMA (certified medication aide) as ordered by physician.

Review of the September 2018 medication administration record revealed resident required glucometer testing for blood sugar level 3 times a day before meals and received Novolog insulin sliding scale with dose based on blood sugar

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S3166	Continued From page 7 level. Review of employee files at 12:31 p.m. on 9/11/18 for CMA D hired 4/21/18, CMA G hired 1/19/17, and CMA H hired 1/28/18 revealed the lack of documentation of licensed nurse delegation of use of glucometer to obtain each resident's blood sugar level. Licensed nurse C confirmed CMAs performed glucometer testing. Licensed nurse C stated he/she had not completed delegation with these CMAs and could not locate documentation of delegation by another licensed nurse. For resident's #200 and #500, operator B failed toensure a licensed nurse delegated the nursing procedure of glucometer testing to each CMA under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto	S3166		
S3200 SS=J	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route.	S3200		

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S3200	Continued From page 8 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(2) The facility reported a census of 28 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1 (#200) of 1 sampled resident requiring insulin and 1 (#500) of 1 focus review resident requiring insulin, operator B failed to ensure medication aides did not administer medication through the parenteral route. This failure placed resident #200 and resident #500 in immediate jeopardy for harm, injury, or death. Based on record review and interview for 1 (#300) of 3 residents sampled, operator B failed to ensure a medication was administered in accordance with a medical care provider's written order and standard of practice. Based on record review and interview for 2 (#300 and #400) of 3 residents sampled, operator B failed to ensure each resident's medication allergies were listed on each resident's medication administration record according to standards of practice. Findings included: - Record review for resident #200 revealed an admission date of 6/1/18 with diagnoses of type 2 diabetes mellitus, chronic obstructive pulmonary disease, and hypertension. Functional capacity screen dated 8/21/18 indicated resident required physical assistance	S3200		

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S3200	Continued From page 9 with management of medications. Negotiated service agreement (NSA) dated 8/21/18 documented management of medication "Per nurse/CMA (certified medication aide) as ordered by physician." Health care service plan (HCSP) dated 8/21/18 documented resident "Takes medication willingly." Record contained hospital discharge orders dated 8/21/18 for resident to begin receiving Novolog insulin with dose determined by blood sugar readings. (Resident was not receiving insulin prior to hospitalization). NSA/HCSP lacked a description of services regarding insulin injections. Resident's record lacked an assessment of resident's ability to inject insulin. August 2018 medication administration record (MAR) recorded resident to start receiving Novolog insulin on 8/21/18 with dose determined by blood sugar readings (obtained with a glucometer) at 7:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. The MAR listed blood sugar range with dose resident required as follows: 150-200 = 3 units 201-250 = 4 units 251-300 = 5 units 301 and above = 6 units and notify medical care provider. The MAR documented a change in the medical care provider's order for Novolog sliding scale insulin on 8/24/18 as follows: 150-200 =5 units 201-250 =6 units 251-300= 7 units	S3200		

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S3200	Continued From page 10 301 and above =8 units and notify medical care provider. The MAR contained documentation by certified staff D that resident received 6 units of Novolog insulin on 8/23/18 and 8/24/18. Certified staff E documented resident received 6 units of Novolog insulin on 8/22/18, 8 units on 8/24/18, and 5 units on 8/27/18. Certified staff F documented resident received 6 units on 8/23/18 and 8 units on 8/25/18. The September 2018 MAR documented the same sliding scale insulin dose as ordered on 8/24/18. The MAR indicated resident did not require insulin administration 9/1/18 through 11:00 a.m. 9/11/18. Review of resident's 4 times a day blood sugar reading beginning at 4:00 p.m. on 8/21/18 through 11:00 a.m. on 9/11/18 revealed readings above 150 with documentation of how many units indicated and initials of licensed and certified staff. The August and September 2018 MARs lacked documentation that resident received insulin each time blood sugar was 150 or above. During an interview at 1:19 p.m. on 9/5/18, licensed nurse C stated 2 residents required insulin injections and certified medication aide or nurse prepared and dialed dose on insulin pen and each resident self-injected insulin. At 12:31 p.m. on 9/11/18, licensed nurse C was unable to provide documentation that a licensed nurse delegated preparation and dialing of an insulin pen to certified medication aides. During an interview with resident #200 at 1:05 p.m. on 9/11/18, when asked about insulin injections, resident stated "They do it all."	S3200		

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S3200	Continued From page 11 Resident confirmed he/she did not self-inject insulin. At 1:10 p.m. on 9/11/18, surveyor asked certified staff D if he/she injected insulin for resident #200. Certified staff D stated "Yes, as a med aide." During an interview at 2:16 p.m. on 9/11/18, when asked if he/she injected resident's insulin, certified staff E stated he/she handed insulin pen to resident, but resident did not want to inject insulin, so he/she helped the resident. Certified staff E stated "most of the time" he/she pierced the resident's skin with the needle and pushed the button on the insulin pen. Operator B failed to ensure medication aides did not administer insulin to resident #200 through the parenteral route. - During an interview at 1:15 p.m. on 9/11/18, focus review resident #500 stated he/she did not self-inject insulin. Resident stated "the nurses inject 8 units (insulin) at bedtime." Record review for resident #500 revealed an admission date of 6/1/17 with diagnosis of type 2 diabetes mellitus. Functional capacity screen dated 5/10/18 indicated resident required physical assistance with medication management. Negotiated service agreement dated 5/10/18 documented medication management "Per nurse/CMA (certified medication aide) as ordered by physician. Review of the July 2018, August 2018, and September 2018 medication administration	S3200		

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S3200	Continued From page 12 records (MAR) revealed resident received Lantus insulin 12 units at 8 p.m. every night with a decrease to 8 units every night beginning 8/20/18. Each of 3 monthly MARs documented resident to receive and Novolog insulin 3 times a day based on blood sugar readings of 150-200 =2 units, 201-250 =3 units, 251-300 = 4 units, and 301-400 =5 units. The MARs contained the initials of certified staff D, certified staff E, certified staff F, certified staff G, and certified staff H for the daily bedtime dose of Lantus insulin. The July, August, and September MARs each contained initials of certified staff E that resident required sliding scale insulin on July 7, 8, 22, 23, 30; August 10, 31; and September 1,8. The August MAR contained the initials of certified staff F on 8/25/18 that resident required sliding scale insulin. During an interview at 1:19 p.m. on 9/5/18, licensed nurse C stated 2 residents required insulin injections and certified medication aide or nurse prepared and dialed dose on insulin pen and each resident self-injected insulin. At 12:31 p.m. on 9/11/18, licensed nurse C was unable to provide documentation that a licensed nurse delegated preparation and dialing of an insulin pen to certified medication aides. During an interview at 2:16 p.m. on 9/11/18, when asked if he/she injected resident's insulin, certified staff E stated he/she handed insulin pen to resident, but resident did not want to inject insulin, so he/she helped the resident. Certified staff E stated "most of the time" he/she pierced the resident's skin with the needle and pushed the button on the insulin pen. Operator B failed to ensure medication aides did not administer insulin to resident #500 through the parenteral route.	S3200		

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S3200	Continued From page 13 For resident #200 and #500, the operator's failure to ensure medication aides did not administer medication through the parenteral route placed these residents in immediate jeopardy for harm, injury or death. The jeopardy was removed at 4:07 p.m. on 9/11/18 when licensed nurse C provided a written plan to correct the issue of certified staff administering insulin as follows: Nurse will assess resident for ability to self-inject insulin and give resident teaching until able to safely and comfortably be able to self-inject at all blood sugar-insulin times. Nurse will give insulin until resident is able to. Once resident able to self-inject correctly for nurse, nurse will teach CMA (certified medication aide) the correct procedure for them. They will be able to dial up the pen for resident correctly in front of nurse and be able to tell nurse correct steps and be signed off on demonstration procedure form. Only when able to demonstrate and tell nurse procedures for CMA will they be able to take insulin pen to resident's room unsupervised. This will begin today 9/11/18. - Record review for resident #300 revealed an admission date of 2/23/16 with diagnoses of Alzheimer's dementia, coronary artery disease, and hypertension. Functional capacity screen dated 7/20/18 indicated resident required physical assistance with management of medications and medical	S3200		

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MORNINGSTAR CARE HOMES OF FREDONIA	2111 E WASHINGTON STREET FREDONIA, KS 66736

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S3200	Continued From page 14 treatments. Negotiated service agreement dated 7/20/18 documented management of medications and treatments "Per nurse/CMA (certified medication aide) as ordered by physician." Health care service plan dated 7/20/18 documented provision of management of treatments. Resident's record contained a written medical care provider's order signed 8/17/18 of Mycolog (anti-fungal/corticosteroid) cream apply daily in response to licensed nurse C's written request for treatment of resident's red and irritated peri-area. The August medication administration record (MAR) lacked documentation resident received the topical medication. During an interview at 11:12 a.m. on 9/11/18, licensed nurse C confirmed the August MAR did not contain the ordered Mycolog cream. Licensed nurse C stated he/she did not write new medication orders on the MAR until he/she received the medication from the pharmacy and apparently the pharmacy did not deliver the Mycolog. Licensed nurse C went to the medication room to look for the medication and did not find. Licensed nurse C confirmed the resident did not receive the medication as ordered by the medical care provider. The resident's September 2018 MAR documented no known drug allergies. Hospital discharge orders dated 9/2/18 documented resident allergic to Levaquin and Macrodantin (antibiotics). During an interview at 10:26 a.m. on 9/11/18,	S3200		

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S3200	Continued From page 15 licensed nurse C stated medication allergies were to be listed on the MAR. Operator B failed to ensure a medication was administered to resident #300 in accordance with a medical care provider's written order and standard of practice and that medication allergies were documented on the residents MAR according to standards of practice. - Record review for resident #400 revealed an admission date of 10/18/17 with diagnoses of type 2 diabetes mellitus and dementia. Resident's admission information sheet listed resident allergic to Cipro and penicillin (antibiotics). Resident's September 2018 medication administration record listed resident with no known drug allergies. During an interview at 10:47 a.m. on 9/11/18, licensed nurse C stated medication allergies were to be listed on the medication administration record. Operator B failed to ensure medication allergies were documented on resident #400's medication administration record according to standards of practice.	S3200		
S3202 SS=E	26-41-205 (d) (4) Delegation of Medication Administration (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.	S3202		

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S3202	Continued From page 16 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(4) The facility reported a census of 28 residents. The sample included 3 residents and 1 focus review resident. Based on record review, observation, and interview for 1 (#200) of 1 sampled resident and 1 (#500) of 1 focus review resident each requiring insulin injections using an insulin pen and 3 of 3 certified medication aide (CMA) employee files reviewed, operator B failed to ensure a licensed nurse delegated the nursing procedure of insulin pen preparation and dialing of correct insulin dose to certified medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included: - At 1:19 p.m. on 9/5/18 along with licensed nurse B, surveyor observed the contents of the medication cart. Licensed nurse C stated 2 residents required insulin injections and certified medication aide or nurse prepared and dialed dose on insulin pen and each resident self-injected insulin. Surveyor observed a Novolog insulin pen labeled for resident #200 and a Novolog insulin pen and Levemir insulin pen each labeled for resident #500 in the medication cart. Review of employee files at 12:31 p.m. on 9/11/18 for CMA D hired 4/21/18, CMA G hired 1/19/17, and CMA H hired 1/28/18 revealed the lack of documentation of licensed nurse delegation of preparation on dialing an insulin pen to each CMA. Licensed nurse C stated each of the CMAs prepared and dialed insulin pens for residents	S3202		

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S3202	Continued From page 17 (#200 and #500) who required insulin. Licensed nurse C stated he/she had not completed delegation with these CMAs and could not locate documentation of delegation by another licensed nurse. For resident's #200 and #500, operator B failed to ensure a licensed nurse delegated the nursing procedure of insulin pen preparation and dialing of correct insulin dose to certified medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S3202		
S3225 SS=E	26-41-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the facility and each time the resident experiences any significant change in condition. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l) The facility reported a census of 28 residents. The sample included 3 residents and 1 focus review resident. Based on record review and	S3225		

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S3225	Continued From page 18 interview for 3 (#300, #400, and #200) of 3 residents sampled, the operator failed to ensure a licensed pharmacist conducted a medication regimen review at least quarterly for each resident whose medication was managed by the facility and each time the resident experienced any significant change in condition. Findings included: - Record review for resident #300 revealed an admission date of 2/23/16 with diagnoses of Alzheimer's dementia and coronary artery disease. Functional capacity screen dated 7/20/18 indicated resident required physical assistance with medication management. Negotiated service agreement dated 7/20/18 documented medication management by nurse and certified medication aide (CMA) according to physician's orders. Record contained a medication regimen review by a licensed pharmacist 8/14/17 and 5/24/18. - Record review for resident #400 revealed an admission date of 10/23/17 with diagnoses of type 2 diabetes mellitus and dementia. Functional capacity screen dated 10/23/17 indicated resident required physical assistance with medication management. Negotiated service agreement dated 10/17/17 documented medication management by nurse and CMA according to physician's orders. Record contained documentation of medication regimen review by a licensed pharmacist dated 5/24/18. - Record review for resident #200 revealed an admission date of 6/1/18 with diagnoses of type 2	S3225		

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S3225	Continued From page 19 diabetes mellitus, chronic obstructive pulmonary disease, and hypertension. Functional capacity screen dated 8/21/18 indicated resident required physical assistance with medication management. Negotiated service agreement dated 8/21/18 documented medication management by nurse and CMA according to physician's orders. The record lacked a medication regimen review by a licensed pharmacist. During an interview at 11:04 a.m. on 9/11/18, licensed nurse C provided 3 "Consultant Pharmacist Visit Checklist" forms completed by a licensed pharmacist dated 12/15/16, 8/14/17, and 5/24/18. Licensed nurse C stated pharmacist did not conduct a quarterly drug regimen review for residents. The operator failed to ensure a licensed pharmacist conducted a medication regimen review at least quarterly for residents #300, #400, and #200 whose medication was managed by the facility and each time the resident experienced any significant change in condition.	S3225		
S3248 SS=E	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (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; (2) supporting documentation for criminal	S3248		

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S3248	Continued From page 20 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; (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 (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. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(1)(3) The facility reported a census of 28 residents. The sample included 3 residents and 1 focus review resident. Based on record review an interview for 1 of 1 licensed nurse employee file reviewed, the operator failed to ensure the file contained evidence that the employee was a licensed nurse at the time of employment and for 1 of 4 certified staff employee files reviewed, operator B failed to verify with the Kansas nurse aide registry, at the time of or prior to employment, that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home. Findings included: - Review of the employee files with licensed	S3248		

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S3248	Continued From page 21 nurse C at 11:54 a.m. on 9/11/18 revealed the following: Licensed nurse J hired 2/1/18 with documentation from the Kansas Board of Nursing for proof of licensure dated 6/18/18. Certified staff K hired 7/9/18 with Kansas nurse aide verification dated 7/23/18. During a phone interview at 2:33 p.m. on 9/11/18, operator B stated he/she audited employee files and found that the licensed nurse's file lacked proof of licensure and printed the document on 6/18/18. Operator B stated certified staff K began working on 7/14/18 and confirmed he/she did not check the nurse aide registry until 7/23/18. The operator failed to ensure licensed nurse J's file contained evidence that the employee was a licensed nurse at the time of employment and operator B failed to verify with the Kansas nurse aide registry, at the time of or prior to employment, that certified staff K did not have a finding of having abused, neglected, or exploited a resident in an adult care home.	S3248		
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 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	S3310		

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S3310	Continued From page 22 (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: KAR 26-41-207(c) The facility reported a census of 28 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 4 of 5 employee files reviewed, the operator failed to 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. Findings included: - Review of employee files at 11:54 a.m. on 9/11/18 with licensed nurse C revealed the lack of compliance with the department's tuberculosis (TB) guidelines as follows: Licensed nurse J hired 2/1/18 with documentation of one TB skin test on 10/30/17. The file lacked documentation of a two-step TB skin test within 6 months prior to hire date or a second TB skin test when hired. Certified staff H hired 1/28/18 with documentation of a TB skin test on 5/22/18 and 6/17/18. Employee lacked documentation of a two-step TB skin test with first test within 7 days of employment.	S3310		

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S3310	Continued From page 23 Certified staff K hired 7/9/18 with no documentation of TB skin testing. Licensed nurse C stated he/she was waiting for employee to bring in TB test from previous employer. Licensed nurse C confirmed TB testing not initiated within 7 days of employment. Certified staff G hired 1/19/17 with documentation of TB skin testing on 10/24/17 and 11/18/17. Employee lacked documentation of a two-step TB skin test with first test within 7 days of employment. The operator failed to 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.	S3310		