STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006004	A. BUILDING: _____ B. WING _____	05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	1126 S HORTON FORT SCOTT, KS 66701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named home plus facility located in Fort Scott conducted on 5-23-18, 5-24-18 and 5-29-18.	S 000		
S5185 SS=E	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(c) The facility reported a census of 9 residents. The sample included 3 residents and 4 focus review residents. Based on record review and interview for 1 (#323) of 3 sampled residents and 1 (#504) focus review resident with an order for a mechanically altered diet, the operator failed to ensure the diet shall be prepared according to instructions from a medical care provider or license dietitian.	S5185		

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
	B006004	A. BUILDING: _____ B. WING _____	05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	1126 S HORTON FORT SCOTT, KS 66701

(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
S5185	Continued From page 1	S5185		

Findings included:

- Record review for Resident #323 revealed admission on 9-21-16 with diagnoses Chronic Depression, Alzheimer's Dementia with Psychotic Overlay.

The Functional Capacity Screen (FCS) dated 3-12-18 recorded resident unable to perform eating (must be fed by caregiver).

The Negotiated Service Agreement (NSA) dated 3-14-18 stated: Regular diet, physical assist needed.

Physician orders dated 3-18-18: "Regular diet puree at times"

Nurse's Notes for 3-18-18: "Received notice unable to swallow well and eat...Sent message to primary care provider. Will monitor." Signed by Licensed Staff C.

Nurse's Note for 3-19-18: "Order received today to have Pureed as needed.." Signed by Licensed Staff C.

- Record review for Resident #504 revealed admission on 5-15-14 with diagnoses Dementia and Hallucinations.

The Functional Capacity Screen (FCS) dated 3-13-18 recorded resident unable to perform eating (must be fed by caregiver).

The Negotiated Service Agreement (NSA) dated 3-14-18 stated: "Diet Regular times one assist when eating (pureed)." Plan of Care Summary Special Instructions: "3-19-18 Resident new order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006004	A. BUILDING: _____ B. WING _____	05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	1126 S HORTON FORT SCOTT, KS 66701

(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
S5185	Continued From page 2 to be pureed diet as needed." Nurse/Physician Fax Communication on 3-16-18: "Resident won't eat or swallow very well. Can we have orders of pureed as needed. Please advise." Physician responded "Yes" and signed on 3-19-18. Interview on 5-23-18 at 4:06 PM with Administrative Staff A confirmed the facility lacked written instructions on how to puree the resident's diet. Interview on 5-23-18 at 4:17 PM with Dietary Staff E stated he/she purees the food for Residents #323 and #504. Stated he/she "grinds the vegetables separately from the meat; and grinds meat and mashed potatoes together with chicken broth." Confirmed there were no written instructions to follow for preparing a pureed diet. For residents #323 and #504, the operator failed to ensure the mechanically altered diet was prepared according to instructions from a medical care provider or licensed dietitian.	S5185		
S5205 SS=F	26-42-104 (a) Disaster and Emergency Preparedness a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(a)	S5205		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006004	A. BUILDING: _____ B. WING _____	05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	1126 S HORTON FORT SCOTT, KS 66701

(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
S5205	Continued From page 3 The facility reported a census of 9 residents. The sample included 3 residents and 4 focus review residents. Based on observation, record review and interview for all residents, the operator failed to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. Findings included: - Review of the resident roster on 5-23-18 revealed 7 residents with impaired cognition. Entrance tour on 5-23-18 from 1:30 PM to 2:15 PM revealed a front door which exits down several steps; a kitchen to right of entryway with an exit through a garage. Directly in front of entryway was a large central common area (living room). To the right of the living room was a sunroom/porch and a dining room. One resident's room was adjacent to the dining room on the opposite side. To the left of the entryway there was a hallway with an office and two resident's rooms at the end of the hallway. Going through the living room, on the far side (away from the front entry) is a hallway and a shared room with two residents. Down this hall is an outside door to the patio; to the left then right is an additional back hallway with another outside door at the end. There are four rooms on this back hall with one resident in each room. Each exit door was equipped with magnetic key pad locks designed to release if the fire alarm sounded. Interview on 5-23-18 at 12:30 PM with Administrative Staff A identified the following staffing schedule for the facility: 12-hour shift at night from 8:00 PM to 8:00 AM with 1 staff member. For day shift, one comes at 7:00 AM	S5205		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006004	A. BUILDING: _____ B. WING _____	05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	1126 S HORTON FORT SCOTT, KS 66701

(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
S5205	Continued From page 4	S5205		

another staff comes at 8:00 AM. There are 2 staff on until 2:00 PM. From 2:00 PM to 4:00 PM there is 1 staff. From 4:00 PM to 8:00 PM there are 2 staff. Administrative Staff A confirmed there is usually only one certified staff every day from 8:00 PM to 8:00 AM.

Interview on 5-24-18 at 10:18 with Administrative Staff A identified 5 residents who used wheelchairs. Of these five, 4 would require staff assistance to transfer into the wheelchair and be pushed out of the facility. Of the remaining 4 ambulatory residents, 3 required a walker and would require staff instructions to exit facility and/or assistance to walk down steps if exiting from front entrance. Administrative Staff A further confirmed all resident's Negotiated Service Agreements lacked documentation of assistance each resident would require to safely evacuate the home.

Certified Staff B provided a copy of the schedule for May 2018.

Surveyor determined in the event of a disaster or emergency evacuation, one staff on duty would be extremely challenged to transfer and move four wheelchair bound residents to safety and simultaneously guide/coax/assist 5 other ambulatory (four with assistive devices) to safety. If the disaster or emergency event was a fire, all five doors would also be released, allowing cognitively impaired residents to exit without monitoring for safety once outside the home. Those going out of the front door would be confronted with steps to descend.

For all residents, the operator failed to ensure the provision of a sufficient number of staff members to take residents who would require assistance in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006004	A. BUILDING: _____ B. WING _____	05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	1126 S HORTON FORT SCOTT, KS 66701

(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
S5205	Continued From page 5 an emergency or disaster to a secure location.	S5205		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (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 home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' 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 26-42-104(d)(3) The facility reported a census of 9 residents. The sample included 3 residents and 4 focus review residents. Based on record review and interview for all residents and staff, the operator failed to ensure disaster and emergency preparedness by ensuring quarterly review of the home's emergency management plan with employees and residents. Findings included: - Review of facility emergency management plan	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006004	A. BUILDING: _____ B. WING _____	05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	1126 S HORTON FORT SCOTT, KS 66701

(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
S5215	Continued From page 6 on 5-23-18 with operator revealed the plan documented review with residents and staff on 4-1-18 and 8-7-17. The plan lacked documentation of a routine quarterly review with residents and staff. Interview on 5-23-18 at 2:15 PM with Administrative Staff A and Certified Staff B confirmed the plan lacked documentation of quarterly review with residents and staff. Facility policy for "Disaster and Emergency Preparedness" stated: This facility will ensure disaster and emergency preparedness by 1. orienting new employees at the time of employment to the facility's emergency management plan. 2. periodically reviewing the plan with employees through in-service. The policy lacked the requirement for quarterly review of the emergency plan with staff and residents. For all residents and staff, the operator failed to ensure disaster and emergency preparedness by ensuring quarterly review of the home's emergency management plan with employees and residents.	S5215		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting;	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006004	A. BUILDING: _____ B. WING _____	05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	1126 S HORTON FORT SCOTT, KS 66701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5230	Continued From page 7 (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 9 residents. The sample included 3 residents and 4 focus review residents. The operator failed to ensure the home's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, as evidenced by record review and interview for 2 (D, F) of 2 sampled staff and affecting all residents. Findings included: - Personnel record review on 5-23-18 at 4:22 PM with Administrative Staff A revealed the following: Certified Staff F with date of hire 3-24-18: The record contained documentation of a chest x-ray dated 10-11-2010. The record lacked documentation of a a TB symptom screen questionnaire and a chest x-ray performed within the last 5 years. Licensed Staff D with date of hire "a couple of weeks" ago to help with admissions and take call while Licensed Staff C is gone": The record contained TB skin testing performed on 9-1-16 and 9-12-16. The record lacked documentation of a TB symptom screening questionnaire completed on or within seven days of date of hire	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006004	A. BUILDING: _____ B. WING _____	05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	1126 S HORTON FORT SCOTT, KS 66701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5230	Continued From page 8 and a 2-step TB skin test. Interview on 5-23-18 at 4:22 PM during personnel record review with Administrative Staff A confirmed the above personnel files lacked documentation of a TB symptom screening questionnaire completed on of within seven days of date of hire, 2-step TB skin testing or an additional chest x-ray completed within 5 years of date of hire. Facility "Infection Control" policy stated: 7. Tuberculosis skin testing of each new resident and employee as soon as residency or employment begins, if the resident or employee provides documentation of a previous significant reaction, the (facility) shall follow the centers for disease control recommendations for preventions and control of tuberculosis in facilities providing long term care to the elderly. For Certified Staff F and Licensed Staff D, the operator failed to ensure the home's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S5230		
S5251 SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by:	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006004	A. BUILDING: _____ B. WING _____	05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	1126 S HORTON FORT SCOTT, KS 66701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 9 KAR 26-42-105(f)(11) The facility reported a census of 9 residents. The sample included 3 residents and 4 focus review residents. Based on record review and interview for 1 (#425) of 3 sampled residents and 3 (#501, #502, #503) focus review residents, the operator failed to ensure 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: - Record review for Resident #425 revealed admission on 5-18-18 with diagnoses Dementia, Alzheimer's Disease, Osteoporosis and Hypothyroidism. The record lacked documentation of date/time of arrival to facility and a nursing assessment. - Record review for Resident #501 revealed admission on 5-18-18 with diagnosis Heart Failure. The record lacked documentation of date/time of arrival to the facility and a nursing assessment. - Record review for Resident #502 revealed admission on 5-18-18 with diagnosis Schizophrenia. The record lacked documentation of date/time of arrival to the facility and a nursing assessment. - Record review for Resident #503 revealed admission on 5-17-18 with diagnosis Heart Failure. The record lacked documentation of date/time of arrival to the facility and a nursing assessment. The records lacked documentation of resident's	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006004	A. BUILDING: _____ B. WING _____	05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	1126 S HORTON FORT SCOTT, KS 66701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 10 admissions to the facility, nursing assessments upon admission and any nurse's notes including communication with physician. Interview on 5-23-18 at 4:40 PM with Certified Staff B confirmed the records lacked documentation in the nurse's notes of date and time of arrival to facility, and nursing assessment. For residents #425, #501, #502, #503, the operator failed to ensure documentation of resident's admission including date/time of arrival and a nursing assessment.	S5251		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (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 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 carehome; 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 work as a certified nurse aide.	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006004	A. BUILDING: _____ B. WING _____	05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	1126 S HORTON FORT SCOTT, KS 66701

(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
S5258	Continued From page 11 This REQUIREMENT is not met as evidenced by: KAR 26-42-102(d)(1)(2) The facility reported a census of 9 residents. The sample included 3 residents and 4 focus review residents. The facility identified 2 employees hired since last survey, with 1 certified staff and 1 licensed staff reviewed. The operator failed to ensure the employee records contained evidence of licensure or certification for each employee performing a function that required specialized education or training; and further failed to ensure the employee records contained supporting documentation for criminal background checks pursuant to K.S.A. 39-970 and amendments thereto before providing care to residents as evidenced by record review and interview for 1 (F) of 1 certified staff, and 1 (D) of 1 licensed staff reviewed. Findings included: - Record review on 5-23-18 at 4:22 PM of employee records with Administrative Staff A revealed the following: Certified Staff F with date of hire 3-24-18: the record lacked documentation of certification and a criminal background check. Licensed Staff D with date of hire "a couple of weeks" ago to help with admissions and take call while Licensed Staff C is gone": the record lacked documentation of evidence of licensure. Interview on 5-23-18 at 4:22 PM with	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006004	A. BUILDING: _____ B. WING _____	05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	1126 S HORTON FORT SCOTT, KS 66701

(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
S5258	Continued From page 12 Administrative Staff A confirmed the above personnel files lacked documentation of certification and criminal background checks. Administrative Staff A provided a copy of Certified Staff F's certification/criminal background check and Licensed Staff D's licensure verification on 5-24-18. Facility policy for staff qualifications stated: 4) the employee records and agency staff records shall contain the following documentation: 1. evidence of licensure, registration, certification...for each employee performing a function that requires specialized education or training. 2. supporting documentation for criminal background checks of facility staff and contract staff... The operator failed to ensure the employee records contained documentation that the registry was checked before providing care to residents for certified and licensed staff and further failed to ensure the criminal background check was documented on certified staff.	S5258		