STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 are the result of a Licensure Resurvey at the above named Assisted Living Facility in Lincoln, Kansas on 5/15/18, 5/16/18, 5/17/18, 5/21/18, 5/22/18, and 5/23/18.	S 000		
S3015 SS=F	26-41-101 (c) Administration Position Description (c) Administrator and operator position description. Each licensee shall adopt a written position description for the administrator or operator that includes responsibilities for the following: (1) Planning, organizing, and directing the facility; (2) implementing operational policies and procedures for the facility; and(3) authorizing, in writing, a responsible employee who is 18 years old or older to act on the administrator ' s or operator's behalf in the absence of the administrator or operator. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(c) The census equalled six the sample included three Residents. Based on observation and interview, for all Residents, Residents' family members, Residents' legal representatives, and employees of facility, the licensee failed to adopt operational policies and procedures for the facility that authorized in writing a responsible employee to act on the administrator's behalf in the absence of the administrator. Findings included: - Review of assignment information identified "Operator of facility" as administrator #D.	S3015		

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
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3015	Continued From page 1 Upon entrance to facility on 5/15/18 at 3:30pm, human resource staff #E stated administrator #D is the "Operator" of the Assisted Living... he/she is out of facility until Thursday 5/17/18. By observations in facility 5/15/18 and 5/16/18, no posting located with designation of employee in charge in the absence of administrator #D. On 5/16/18 at 10:00am, when asked who is in charge when administrator #D absent, director of nursing #F stated "I have no idea... I've only been here since January... not aware if anything written out for who's in charge when #D gone... ask human resources #E... he/she may know. On 5/16/18 at 10:30am, when asked who is in charge when administrator #D absent, human resource staff #E stated everything here is under one license, Assisted Living and Skilled Care... when administrator #D is gone then director of nursing #F is in charge of everything... not aware of anything in writing... On 5/21/18 at 2:05pm administrator #D stated we have a "calling tree"... I don't post a sign when I leave who is in charge... as far as designating that in writing we have the calling tree... For all Residents, employees, visitors, and family members, the licensee failed to adopt operational policies and procedures for the facility that authorized in writing a responsible employee to act on the administrator's behalf in the absence of the administrator.	S3015		
S3030 SS=F	26-41-101 (g) Availability of Policies and Procedures	S3030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3030	Continued From page 2 (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(g) The census equalled six the sample included three Residents. Based on observations and interviews, the administrator failed to ensure policies and procedures related to Resident services were available to staff at all times and to all Residents, legal representatives, case managers, and families during normal business hours, with a notice of availability posted in a place readily accessible to Residents. Findings included: - By observations in facility 5/15/18 and 5/16/18, no posting located for availability of Resident services policies and procedures. On 5/16/18 at 10:00am, and at 2:15pm, director of nursing #F stated you will probably have to ask human resource staff #E about policies and procedures... I've only been here since January... not sure where those are kept or if any posting... On 5/16/18 at 10:30am and at 3:25pm, human resources #E stated would need to ask	S3030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3030	Continued From page 3 administrator #D or whoever is on duty in the Assisted Living unit about policies and procedures... we have been under construction for five months... not sure where those are right now... On 5/21/18 at 2:05pm administrator #D stated our policies and procedures are available over the Internet... not everyone has sign on capabilities... the administrator, the director of nursing, possibly the MDS (minimum data set) nurse... not all employees have access nor do families or Residents... The Administrator failed to ensure policies and procedures related to Resident services were available to staff at all times and to all Residents, legal representatives, case managers, and families during normal business hours, with a notice of availability posted in a place readily accessible to Residents.	S3030		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by:	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3081	Continued From page 4 KAR 26-41-201(c) The census equalled six the sample included three Residents. Based on reviews of records and interview, for one of three sampled (#185), the Administrator failed to ensure designated facility staff conducted a functional capacity screen (FCS) at least once every 365 days. Findings included: - Review of record revealed #185 admitted to facility 9/21/15 with diagnoses of diabetes, dyspepsia, insomnia, hypertension, atrial fibrillation, depressive disorder, anxiety, osteoarthritiis, and gastroesophageal reflux disease. By review, the current and only FCS in medical record dated 9/16/15. This FCS failed to correspond with the elements and definitions specified by the department. These codes indicated #185 needed supervision with activities of daily living and was unable to perform medication and treatment management. The medical record lacked any annual revisions, or indication of annual review. On 5/16/18 at 2:15pm, director of nursing #F stated the FCS for #185 was completed before I got here... there may be something more appropriate in overflow but medical record staff is not here on Wednesday... The Administrator failed to ensure designated facility staff conducted an FCS at least once every 365 days.	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3085	Continued From page 5	S3085		
S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a) The census equalled six the sample included three Residents. Based on observations, interviews, and reviews of records, for one of three sampled (#189), the Administrator failed to ensure the negotiated service agreement (NSA) included a description of service the Resident would receive, and identification of each party responsible for payment if outside resources provide a service. Findings included: - Review of record revealed #189 admitted to	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3085	Continued From page 6	S3085		

facility 5/11/12 with diagnoses of anxiety, depressive disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, gastroesophageal reflux disease, anemia, and osteoarthritiis.

Current functional capacity screen of 5/04/18 assessed #189 in need of physical assistance with bathing and treatments; in need of supervision with dressing, toileting, and medication management; with occasional incontinence, decision making impairment, falls and unsteadiness, used a walker, wheelchair, and electric scooter.

Current NSA of 5/04/18 documented #189 to receive assistance with bathing; assistance with dressing as needed; daily emptying of bedside urinal.
The NSA documented "regular" diet, and failed to include the low sodium diet ordered by physician 3/27/18.
The NSA documented staff to administer all medications, and also "Resident may self medicate or keep at bedside."
The NSA lacked the medications self administered by the Resident
The NSA lacked the service of continual oxygen, physician ordered by signature on 3/27/18.
The NSA lacked the provider of oxygen, and lacked the payment source of the oxygen.
The NSA documented "lab draws as ordered" but failed to identify what lab tests, how often, or who completed the lab draws, and if an outside provider, the payment source.
The NSA failed to identify the source of transportation, with all options - family/facility, and physician appointments/activities, shopping all left blank.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3085	Continued From page 7 On 5/16/18 at 2:15pm, director of nursing #F confirmed the NSA lacked a description of services... for lab testing stated the hospital staff draws the lab tests... and self administered medications... stated this NSA was on my desk until this morning... I just put it in the medical record... The Administrator failed to ensure the development of an NSA which included a description of services #189 to receive, the provider of oxygen and lab draws, and the payment source for these services.	S3085		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The census equalled six the sample included three Residents. Based on interviews and reviews of records, for two of three sampled (#187 and #189), the Administrator failed to ensure the negotiated service agreement (NSA) contained the name of the licensed nurse responsible for the implementation and supervision of the health service plan (HSP). Findings included:	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3165	Continued From page 8 - Review of record revealed #187 admitted to facility 8/04/14 with diagnoses of post gastric survey syndrome, weakness, hypertension, congestive heart failure, and history of falling. The current 9/06/17 FCS (functional capacity screen) assessed #187 in need of supervision with bathing; in need of physical assistance with medication and treatment management; with occasional bladder incontinence, memory recall impairment, falls/unsteadiness, with vision and hearing impairments, and used a walker for ambulation. The current 9/06/17 NSA (negotiated service agreement) and Health Care Service Plan documented #187 to receive services to address needs identified on 9/06/17 FCS. The NSA contained the signature of a nurse no longer at the facility. The NSA lacked the designation of the name of the nurse responsible for the implementation and supervision of the HSP. - Review of record revealed #189 admitted to facility 5/11/12 with diagnoses of anxiety, depressive disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, gastroesophageal reflux disease, anemia, and osteoarthritiis. Current functional capacity screen of 5/04/18 assessed #189 in need of physical assistance with bathing and treatments; in need of supervision with dressing, toileting, and medication management; with occasional incontinence, decision making impairment, falls and unsteadiness, used a walker, wheelchair, and electric scooter.	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3165	Continued From page 9 The current 5/04/18 Negotiated Service Agreement (NSA) documented facility to provide services to meet the needs identified in the FCS. The NSA lacked services to address physician's orders for continual oxygen, for physician ordered low sodium diet, for lab testing, and for self administration of select medications. The NSA lacked the designation of the name of the nurse responsible for the implementation and supervision of the HSP. On 5/15/18 at 3:30pm, human resource staff #E stated our director of nursing #F over the skilled unit is also the nurse over the Assisted Living... he/she is not here today... he/she is over the health services... On 5/16/18 at 10:00am director of nursing #F confirmed he/she completed the negotiated service agreements and health service plans... The Administrator failed to ensure the NSA's for #187 and #189 contained the name of the licensed nurse responsible for the implementation and supervision of the HSP.	S3165		
S3175 SS=E	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3175	Continued From page 10 without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The census equalled six the sample included three Residents. The Resident roster identified one Resident who self administered medications and that person included in the sample. Based on interviews, and reviews of records, for two of three sampled who self-administered select medications (#185 and #189), the Administrator failed to ensure a licensed nurse performed an assessment of the Resident's ability to safely and accurately self-administer medications. Findings included: - Review of record revealed #185 admitted to facility 9/21/15 with diagnoses of diabetes, dyspepsia, insomnia, hypertension, atrial fibrillation, depressive disorder, anxiety, osteoarthritiis, and gastroesophageal reflux disease. The current functional capacity screen (FCS) of medical record dated 9/16/15. This FCS used letter codes for assessment values that failed to correspond with the elements and definitions specified by the department.	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3175	Continued From page 11 This FCS assessed #185 unable to perform medication and treatment management. The medical record lacked a negotiated service agreement. The May 2018 MAR (medication administration record) documented Zinc Oxide cream for gaulding "may be kept in room" and Refresh Optiva eye drops "use prior to reading/handwork, may keep at bedside." The medical record lacked a self administration assessment of #185's ability to safely and accurately self administer these medications in his/her room. - Review of record revealed #189 admitted to facility 5/11/12 with diagnoses of anxiety, depressive disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, gastroesophageal reflux disease, anemia, and osteoarthritiis. Current functional capacity screen of 5/04/18 assessed #189 in need of supervision with medication management and in need of physical assistance with treatment management. The May 2018 MAR (medication administration record) documented menthol cough drops (may keep at bedside); Tums (for indigestion, may have at bedside); Symbicort inhaler (for obstructive pulmonary disease, may keep at bedside); ipratropium bromide spray (for allergic rhinitis, may keep at bedside). By observation on 5/16/18 at 3:51pm in #189's room, medications on table beside recliner and	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3175	Continued From page 12 beside bed included Tums, Acetaminophen (for pain and fever), Miralax (laxative), Symbicort inhaler, nebulizer breathing treatment machine, and Preservision (eye supplement tablets). #189 confirmed he/she self administered these medications. Current NSA of 5/04/18 documented #189 to receive staff administration of all medications, and also "Resident may self medicate or keep at bedside." The NSA lacked the medications self administered by the Resident. The medical record lacked a self administration assessment of #189's ability to safely and accurately self administer these medications in his/her room. On 5/16/18 at 2:15pm, director of nursing #F stated I doubt if we have a self administration assessments for them... The Administrator failed to ensure a licensed nurse conducted a self-administration assessment of #185 and #189 prior to the self administration of medications.	S3175		
S3200 SS=E	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	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3200	Continued From page 13 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. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(1-2) The census equalled six the sample included three Residents. All Residents with facility managed medications and two self administered select medications. Based on interview and reviews of records, for two of three sampled Residents (#189 and #185), the Administrator failed to ensure all medications and biological's administered to each Resident in accordance with professional standards, and in accordance with written medical care provider orders. Findings included: - Review of record revealed #185 admitted to facility 9/21/15 with diagnoses of diabetes, dyspepsia, insomnia, hypertension, atrial fibrillation, depressive disorder, anxiety, osteoarthritiis, and gastroesophageal reflux disease. The current FCS dated 9/16/15 assessed #185 unable to perform medication and treatment management. The medical record lacked a negotiated service agreement.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3200	Continued From page 14 Comparison of the May 2018 MAR (medication administration record) with written, signed, physician's orders revealed the following: The MAR orders included Guaifenesin liquid for cough. The medical record admission forms, physician visit notes, and the MAR itself documented Guaifenesin as an allergy for #185. The record lacked documentation of licensed nurse effort to clarify with the physician, the reality, presence, or known effects of this allergy, in accordance with professional standards of practice for medication management. The MAR orders included Ibuprofen (analgesic) tablet 600mg (milligrams) one tablet (200mg) oral as needed. This order lacked an indication for use, or frequency. The order contained two different dosages for administration, and failed to define the meaning of 600mg and 200mg in the same order. The record lacked documentation of licensed nurse effort to clarify with the physician, By review, ibuprofen not included in orders signed by physician 4/18/18. Ibuprofen order later located on a phone order dated 4/07/18, signed by physician 4/25/18. The MAR included Amlodipine 5mg one tablet oral at bedtime. The written/signed physician's order for Amlodipine not located in the medical record. Physician order sheet (POS) signed 4/18/18 included Oxybutinin 15mg ER one every morning. The MAR lacked this order. Review of medical record revealed a phone order	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3200	Continued From page 15 with original date of 4/06/18 "discontinue Oxybutinin." Review revealed Oxybutinin daily order included on POS signed by physician 4/18/18. This POS used to prepare the May MAR. The record lacked licensed nurse effort to clarify current status of the order, in accordance with professional standards of practice. - Review of record revealed #189 admitted to facility 5/11/12 with diagnoses of anxiety, depressive disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, gastroesophageal reflux disease, anemia, and osteoarthritiis. Current functional capacity screen of 5/04/18 assessed #189 in need of physical assistance with treatments; in need of supervision with medication management. Current negotiated service agreement of 5/04/18 documented medication management provided by facility and #189 self administered select medications. Comparison of the May 2018 MAR (medication administration record) with written, signed, physician's orders revealed the following: MAR included order for Coumadin (blood thinner) 5mg (milligrams) oral once a day Sun, Mon, Tues, Thu, Sat; 7.5mg oral once a day on Wed, Fri. This MAR order dated 3/27/18. Physician order sheet (POS) signed by physician 3/27/18 documented "Coumadin 5mg on Sun, Mon, Tue, Wed, Thu, Sat; 7.5mg on Fri only. The medical record lacked licensed nurse effort to clarify current status of the order, in accordance with professional standards of practice.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3200	Continued From page 16 On 5/16/18 at 2:15pm director of nursing #F confirmed above issues of MAR's... stated the nurse uses signed orders to prepare MAR's for the month before first day of month... For #189 and #185 the Administrator failed to ensure all medications administered in accordance with professional standards of practice and in accordance with written physician's orders.	S3200		
S3201 SS=E	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(3)	S3201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3201	Continued From page 17 The census equalled six the sample included three Residents. All Residents received medication management by facility and two Residents self administered select medications. Based on observation, interview, and review of record: For three of three sampled with facility managed medications (#189, #187, and #185) and for one non sampled (#182), the Administrator failed to ensure staff remained with the Resident until medication ingested; and For one of two sampled who self administered some medications, the Administrator failed to ensure staff administered only the medication that the licensed nurse or medication aide personally prepared. Findings included: - By observations on 5/16/18 at 11:50am and 12:01pm, during the noon meal service in the dining room, certified medication aide (CMA) #C placed a prepared pill cup beside the dinner plates of #187. CMA #C then returned to the medication cart on the other side of room, documented in the MAR (medication administration record) on the cart, and then prepared the next doses of medication. CMA #C carried pill cups to the table for #189 and #185 and also placed these pill cups beside Resident dinner plates, and returned to the medication cart. In addition to placing the pill cup beside the plate for non-sampled #182, #C also checked the Resident's pulse oximeter reading, and returned to the medication cart before #182 ingested the contents of the pill cup. On 5/22/18 at 2:25pm CMA #A stated we are to take and give them their meds... most of the time	S3201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3201	Continued From page 18	S3201		

we set the pill cups down and go away... chart the meds... I turn my med cart so I can still see what they are doing... they like to take their pills as they are eating or after they finish eating... #182 we have to keep a close eye on him/her because he/she chokes sometimes... they all take them one at a time...

The Administrator failed to ensure staff remained with the Residents until medications ingested.

- Review of record revealed #189 admitted to facility 5/11/12 with diagnoses of anxiety, depressive disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, gastroesophageal reflux disease, anemia, and osteoarthritiis.

Current functional capacity screen of 5/04/18 assessed #189 in need of supervision with medication management and in need of physical assistance with treatment management.

Current NSA of 5/04/18 documented #189 to receive staff administration of all medications, and also "Resident may self medicate or keep at bedside." The NSA lacked the medications self administered by the Resident.

The May 2018 MAR (medication administration record) documented:
Menthol cough drops (may keep at bedside);
Tums (for indigestion, may have at bedside);
Symbicort inhaler (for obstructive pulmonary disease, may keep at bedside);
Ipratropium bromide spray (for allergic rhinitis, may keep at bedside), and
Combivent Respimat (for obstructive pulmonary disease, may keep at bedside).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3201	Continued From page 19 The MAR documented daily facility staff administration of the Symbicort, Combivent, and ipratropium bromide although identified as self administered. By observation on 5/16/18 at 3:51pm in #189's room, medications on table beside recliner and beside bed included Tums, Acetaminophen (for pain and fever), Miralax (laxative), inhalers, nebulizer breathing treatment machine, and Preservision (eye supplement tablets). #189 confirmed he/she self administered these medications. On 5/16/18 at 2:15pm, director of nursing #F confirmed #189 self administered some medications... I don't know why staff initials the meds on the MAR that #189 self administers... On 5/21/18 at 2:05pm administrator #D stated our policies and procedures are available over the Internet... not everyone has sign on capabilities... On 5/22/18 at 2:25pm certified medication aide #A stated #189 does self administer those medications (inhalers stored in room)... we do not administer but we initial the medications to show that we know he/she got them... On 5/16/18 at 3:41pm no medication policies and procedures available for review. For #187, #185, #189, and #182 and all Residents with medications set up and left for self administration, the Administrator failed to ensure staff who prepared medications remained with the Resident until the medication ingested. For #189 who self administered some medications, the Administrator failed to ensure	S3201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3201	Continued From page 20 staff administered (documented) only the medication that the licensed nurse or medication aide personally prepared.	S3201		
S3210 SS=F	26-41-205 (e) (f) Medication Verbal Orders and Standing Orders (e) Medication orders. Only a licensed nurse or a licensed pharmacist may receive verbal orders for medication from a medical care provider. The licensed nurse shall ensure that all verbal orders are signed by the medical care provider within seven working days of receipt of the verbal order. (f) Standing orders. Only a licensed nurse shall make the decision for implementation of standing orders for specified medications and treatments formulated and signed by the resident ' s medical care provider. Standing orders of medications shall not include orders for the administration of schedule II medications or psychopharmacological medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(e) The census equalled six the sample included three Residents. The facility identified one Resident who self administered select medications, and all six with facility managed medications. Based on interviews and reviews of record, for three of three sampled (#185, #187, and #189), the licensed nurse failed to ensure all verbal orders were signed by the medical care provider within seven working days of receipt of the verbal order.	S3210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3210	Continued From page 21 Findings included: - Review of record revealed #185 admitted to facility 9/21/15 with diagnoses of diabetes, dyspepsia, insomnia, hypertension, atrial fibrillation, depressive disorder, anxiety, osteoarthritiis, and gastroesophageal reflux disease. By review, the current and only FCS in medical record dated 9/16/15, used letter codes for assessment values that failed to correspond with the number codes/elements and definitions specified by the department. These codes indicated #185 was unable to perform medication and treatment management. The medical record lacked an NSA. The medical record contained telephone orders not signed within seven days: Ibuprofen 600mg (milligrams) as needed, order written 4/07/18... not signed by physician until 4/25/18 Coumadin (blood thinner) order of 4/30/18, not signed as of 5/16/18 Antibiotic ordered 4/07/18, not signed until 4/25/18 Dipstick urine test ordered 4/11/18, not signed until 4/25/18 POS (physician order sheet) noted by facility nurse 3/12/18, signed by physician 3/27/18 POS noted by facility nurse 5/02/18, not signed as of 5/16/18. - Review of record revealed #187 admitted to facility 8/04/14 with diagnoses of post gastric survey syndrome, weakness, hypertension, congestive heart failure, and history of falling.	S3210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3210	Continued From page 22 The current 9/06/17 FCS (functional capacity screen) assessed #187 in need of physical assistance with medication and treatment management. The current 9/06/17 NSA (negotiated service agreement) and Health Care Service Plan documented #187 to receive medication management by facility. The medical record contained telephone orders not signed within seven days: Discontinue treatment order dated 4/05/18, not signed by physician until 5/16/18 POS (physician order sheet) noted by facility nurse 5/02/18, not signed as of 5/16/18. - Review of record revealed #189 admitted to facility 5/11/12 with diagnoses of anxiety, depressive disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, gastroesophageal reflux disease, anemia, and osteoarthritiis. Current functional capacity screen of 5/04/18 assessed #189 in need of physical assistance with treatments; in need of supervision with medication management. Current NSA of 5/04/18 documented staff to administer all medications, and also "Resident may self medicate or keep at bedside." The medical record contained telephone orders not signed within seven days: Coumadin order of 5/07/18, not signed as of 5/16/18. Hemoglobin order of 5/04/18, no signed as of	S3210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3210	Continued From page 23 5/16/18 POS (physician order sheet) noted by facility nurse 5/02/18, not signed as of 5/16/18 POS noted by facility nurse 3/29/18, not signed until 4/18/18. On 5/16/18 at 2:15pm, director of nursing #F confirmed orders not signed by physician in seven days. The licensed nurse failed to ensure all verbal orders for #189, #187, and #185 were signed by the medical care provider within seven working days of receipt of the verbal order.	S3210		
S3214 SS=D	26-41-205 (g) (4) Sample & Indigent Medication Program Meds (g) (4) Licensed nurses and medication aides may administer sample medications and medications from indigent medication programs if the administrator or operator ensures the development of policies and implementation of procedures for receiving and identifying sample medications and medications from indigent medication programs that include all of the following conditions: (A) The medication is not a controlled medication. (B) A medical care provider ' s written order accompanies the medication, stating the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration. (C) A licensed nurse or medication aide receives the medication in its original, unbroken manufacturer ' s package. (D) A licensed nurse documents receipt of the medication by entering the resident ' s name and the medication name, strength, and quantity into	S3214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3214	Continued From page 24 a log. (E) A licensed nurse places identification information on the medication or package containing the medication that includes the medical care provider ' s name; the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider ' s order. Facility staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches the information on the medical care provider ' s order. (F) A licensed nurse informs the resident or the resident ' s legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies. The resident ' s clinical record shall contain documentation that the resident or the resident ' s legal representative has received the information and accepted the risk of potential adverse consequences. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(4) The census equalled six the sample included three Residents. All Residents identified as having facility managed medications, and two self administered select medications. Based on interviews and reviews of records, for one of one sampled Resident who received a sample medication (#185), the Administrator failed to	S3214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3214	Continued From page 25	S3214		

ensure the development of policies and procedures for receiving and identifying sample medications.

Findings included:

- On 5/15/18 at 4:35pm, during completion of entrance checklist, certified staff #A stated #185 gets a sampled medication... he/she gets insulin through the clinic... not sure about a policy for that...

Review of record revealed #185 admitted to facility 9/21/15 with diagnoses of diabetes, dyspepsia, insomnia, hypertension, atrial fibrillation, depressive disorder, anxiety, osteoarthritiis, and gastroesophageal reflux disease.

The current FCS of medical record dated 9/16/15. This FCS assessed #185 unable to perform medication and treatment management.
The medical record lacked a negotiated service agreement.
The MAR (medication administration record) documented staff administration of Novolog, Humalog, Lantus, Toujeo, and Basaglar insulin to #185.
Clinic visit physician dictations reference supply of sample insulin distributed to #185.

By interview on 5/16/18 at 10:00am, director of nursing #F stated I have no idea about polices for meds in Assisted Living (AL)... may need to ask human resource (HR) staff #E...

By interview on 5/16/18 at 3:24pm HR staff #E stated we have been under construction... not sure about all the policies... I may have to ask Administrator #D about that...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3214	Continued From page 26 On 5/21/18 at 2:05pm requested policies from Administrator #D. On 5/22/18 at 2:10pm no policies received. On 5/22/18 at 2:10pm licensed practical nurse #J confirmed nursing staff of skilled unit administered insulin to #185... confirmed the Basaglar insulin pen a sample from the physician's office. When asked about process for accepting, storing, labeling of sample insulin pen licensed nurse #J stated we mark the pen with #185's name and the date opened... no other labeling or steps used... all other information is on the MAR (medication administration record) for reference... not aware of a sample med policy and procedure. On 5/22/18 at 3:41pm no policies received to review. For #185 the Administrator failed to ensure the development of policies and procedures for receiving and identifying sample medications as required, to include: documentation of receipt of the medication on a log, identifying information placed on package that matches the written order, and obtaining informed consent from Resident or their representative for use of a medication that did not go through usual pharmacy procedures.	S3214		
S3227 SS=E	26-41-205 (l) (2) Medication Regimen Review Variance Report (l) (2) The licensed pharmacist or licensed nurse shall notify the medical care provider upon discovery of any variance identified in the medication regimen review that requires	S3227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3227	Continued From page 27 immediate action by the medical care provider. The licensed pharmacist shall notify a licensed nurse within 48 hours of any variance identified in the resident ' s regimen review that does not require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident ' s medical care provider. The licensed nurse shall seek a response from the medical care provider within five working days of the medical care provider ' s notification of a variance. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l)(2) The census equalled six the sample included three Residents. All Residents with facility managed medications and two Residents self administered select medications. Based on reviews of records and interviews, for two of three sampled (#189 and #185), the Administrator failed to ensure the licensed nurse sought a response from the medical care provider as the result of the pharmacist' variance reports, within five working days. Findings included: - By review, each of these records lacked an individual drug regimen review. On 5/16/18 at 2:15pm director of nursing #F stated I have some pharmacy reviews on my desk... not sure where to find review records in the charts. #F provided manilla folders with pharmacy reviews.	S3227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3227	Continued From page 28 - #189 admitted to facility 5/11/12 with diagnoses of anxiety, depressive disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, gastroesophageal reflux disease, anemia, and osteoarthritiis. 5/04/18 functional capacity screen (FCS) assessed #189 unable to manage treatments, in need of supervision for medications. 5/04/18 negotiated service agreement (NSA) documented #189 to receive these services from facility. #187 admitted to facility 8/04/14 with diagnoses of post gastric survey syndrome, weakness, hypertension, congestive heart failure, and history of falling. 9/06/17 functional capacity screen (FCS) assessed #187 unable to manage medications and treatments. 9/06/17 negotiated service agreement (NSA) documented #187 to receive these services from facility. #185 admitted to facility 9/21/15 with diagnoses of diabetes, dyspepsia, insomnia, hypertension, atrial fibrillation, depressive disorder, anxiety, osteoarthritiis, and gastroesophageal reflux disease. Current functional capacity screen (FCS) of medical record dated 9/16/15 assessed #185 unable to manage medications and treatments. The medical record lacked a negotiated service agreement. Review of manilla envelope contents revealed: Medication Regimen Review completed 01/25/18 - included names of #189, #187, and #185. Variance (note to attending physician) form for #185 requested consideration of change to Ativan order.	S3227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3227	Continued From page 29 This variance/request not yet responded to on 5/16/18. Medication Regimen Review completed 02/23/18 - included names of #189, #187, and #185. Variances (notes to attending physician) forms for #189 requested consideration of change to Ativan and Lipitor orders. These variances/requests not yet responded to on 5/16/18. Medication Regimen Review completed 03/29/18 - included names of #189, #187, and #185. No Variance (note to attending physician) forms included Medication Regimen Review completed 04/19/18 - included names of #189, #187, and #185. No Variance (note to attending physician) forms included The Operator failed to ensure the licensed nurse sought a response from the medical care provider as the result of the pharmacist's variance reports for #185, #189, and #187, within five working days.	S3227		
S3228 SS=F	26-41-205 (l) (3) Medication Regimen Review Record (l) (3) The administrator or operator, or the designee, shall ensure that the medication regimen review is kept in each resident ' s clinical record. This REQUIREMENT is not met as evidenced by:	S3228		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3228	Continued From page 30 KAR 26-41-205(l)(3) The census equalled six the sample included three Residents. Based on reviews of records and interviews, for three of three sampled (#189, #185, and #187), the Administrator failed to ensure the medication regimen reviews kept in each Resident's clinical record. Findings included: - All Residents of facility received medication and treatment management services, two Residents self administered select medications. #189 admitted to facility 5/11/12 with diagnoses of anxiety, depressive disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, gastroesophageal reflux disease, anemia, and osteoarthritiis. 5/04/18 functional capacity screen (FCS) assessed #189 unable to manage treatments, in need of supervision for medications. 5/04/18 negotiated service agreement (NSA) documented #189 to receive these services from facility. #187 admitted to facility 8/04/14 with diagnoses of post gastric survey syndrome, weakness, hypertension, congestive heart failure, and history of falling. 9/06/17 functional capacity screen (FCS) assessed #187 unable to manage medications and treatments. 9/06/17 negotiated service agreement (NSA) documented #187 to receive these services from facility. #185 admitted to facility 9/21/15 with diagnoses of diabetes, dyspepsia, insomnia, hypertension,	S3228		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3228	Continued From page 31 atrial fibrillation, depressive disorder, anxiety, osteoarthritiis, and gastroesophageal reflux disease. Current functional capacity screen (FCS) of medical record dated 9/16/15 assessed #185 unable to manage medications and treatments. The medical record lacked a negotiated service agreement. By review, each of these records lacked an individual drug regimen review. On 5/16/18 at 2:15pm director of nursing #F stated I have some pharmacy reviews on my desk... not sure where to find in the records and they may have been thinned out after the survey in January. For #189, #187, and #185 the Administrator failed to ensure the medication regimen reviews kept in each Resident's clinical record.	S3228		
S3246 SS=F	26-41-102 (b) Staff Qualification Awake - Responsive (b) Direct care staff or licensed nursing staff shall be awake and responsive at all times. This REQUIREMENT is not met as evidenced by: KAR 26-41-102 The census equalled six the sample included three Residents. Based on observations and interviews, for all Residents of Assisted Living facility, the Administrator failed to ensure direct care staff responsive at all times.	S3246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3246	Continued From page 32 Findings included: - On 5/15/18 during completion of entrance conference beginning at 3:30pm, human resource (HR) staff #E stated we have one staff person on duty in the Assisted Living (AL) unit... they go back and forth between skilled unit and AL... locked door with a keypad code to get into AL and a button to press to come back into skilled unit... Observations on 5/15/18 and 5/16/18 revealed a door with numeric keypad for entrance into AL unit from the skilled side, and a black button on the wall to press for entrance from the AL into the skilled unit. On 5/15/18 at 4:35pm by interview of certified staff #A in the skilled unit work room, #A stated I am usually in AL when on duty... if needed in skilled come over here... the AL Residents can turn on call lights if they need something and it rings on the skilled side as well... the door is locked between the Al and skilled... the night shift of skilled unit just goes over and checks on AL Residents and passes any medications needed... start getting people up at 6:45am, over to skilled to get breakfast... back to AL to serve and pass pills... do showers if scheduled... then back to skilled to help... #A confirmed staff not present in AL unit at all times On 5/16/18 at 9:20am certified staff #C stated bathrooms for staff use not in the main AL unit... one located on other side of locked door in skilled unit, and public bathrooms in basement rented venue below AL unit. Certified staff #C stated when here I serve breakfast... pick up dishes and take cart back to skilled unit... assist with breakfast in skilled unit, do any showers	S3246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3246	Continued From page 33 scheduled in AL and then check back in AL couple times while helping out in skilled... Observations 5/16/18 revealed certified staff #C working portions of the day shift in the skilled nursing unit, with the following time periods present in the AL unit: 9:20am to 10:00am 10:45am to 11:17am 11:45am to 12:25pm 1:05pm to 1:10pm 1:35pm to 1:45pm For all Residents of facility, the Administrator failed to ensure direct care staff present in unit and responsive to Residents' needs at all times.	S3246		
S3260 SS=D	26-41-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and	S3260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3260	Continued From page 34 treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(1-10) The census equalled six the sample included three Residents. Based on reviews of record and interviews, for one of three sampled (#185), the Administrator failed to ensure each Resident record contained required components one through ten according to KAR 26-41-105(f)(1) Findings included: - Review of record revealed #185 admitted to facility 9/21/15 with diagnoses of diabetes, dyspepsia, insomnia, hypertension, atrial fibrillation, depressive disorder, anxiety, osteoarthritiis, and gastroesophageal reflux disease. By review, the current and only FCS in medical record dated 9/16/15. This FCS failed to correspond with the elements and definitions specified by the department. FCS codes indicated #185 needed supervision with activities of daily living and was unable to perform medication and treatment management. The medical record lacked an NSA.	S3260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3260	Continued From page 35 On 5/16/18 at 2:15pm director of nursing #F confirmed no NSA in the medical record... stated that was before me... For #185, the Administrator failed to ensure the Residents' records contained required components one through ten according to KAR 26-41-105(f)(1).	S3260		
S3270 SS=E	26-41-104 (b) Written Emergency Plan (b) Each administrator or operator shall ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including the following: (1) Fire; (2) flood; (3) severe weather; (4) tornado; (5) explosion; (6) natural gas leak; (7) lack of electrical or water service; (8) missing residents; and (9) any other potential emergency situations. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(b) The census equalled six the sample included three Residents. Based on observation, interview, and review of record, for all Residents and employees, the Administrator failed to ensure the development of a detailed written emergency management plan that included missing	S3270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3270	Continued From page 36 Residents. Findings included: - By review on 5/16/18, the facility emergency management plan lacked a written plan for missing Residents. The emergency book lacked specific written plans for a natural gas leak and the lack of electrical service, but the plan for fire included shut-off directions for gas and electric and contact numbers for the service providers. On 5/21/18 at 2:05pm, administrator #D confirmed the emergency book lacked written plans for missing persons, natural gas leak, and electric outage... confirmed the fire plan covered shut off procedures and service contact numbers... administrator #D stated we do not admit high acuity Residents into the Assisted Living... if a Resident has cognitive impairments and tendency to wander they are not admitted or are removed when showing symptoms. For all Residents and employees, the Administrator failed to ensure the development of a detailed written emergency management plan that included missing Residents.	S3270		
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	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 37 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) The facility census equalled six the sample included three Residents. The facility identified two employees hired since the last Resurvey and eight total employees. Based on interviews and reviews of records, The Administrator failed to ensure disaster and emergency preparedness by conducting quarterly reviews of the facility's emergency management plan with employees and Residents, and, The Administrator failed to ensure an emergency evacuation drill conducted at least annually with staff and Residents. Findings included: - On 5/15/18 during the entrance conference requested quarterly disaster plan reviews and annual evacuation drills. On 5/16/18 at 10:30am, human resource (HR) staff #E stated we moved all Residents in the skilled unit center hall during a Tornado warning... maybe the 7th or the 9th (May 2018)... but not	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 38 documented that I know of. HR staff #E stated we do an annual disaster training that includes review of the evacuation policy and procedure... did those 10/19/17, 10/20/16, 10/30/15... do not have any quarterly emergency plan reviews with Residents and staff. On 5/21/18 at 2:05pm Administrator #D stated we don't do quarterly reviews of the whole emergency plan book... we do complete monthly fire and tornado drills... For all Residents and employees, the Administrator failed to ensure reviews of the facility's emergency management plan completed quarterly with both employees and Residents and the Administrator failed to ensure an emergency evacuation drill conducted at least annually with staff and Residents.	S3280		
S3290 SS=E	26-41-206 (a) (b) Dietary Services (a) Provision of dietary services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. If the administrator or operator of the facility establishes a contract with another entity to provide or coordinate the provision of dietary services to the residents, the administrator or operator shall ensure that entity ' s compliance with these regulations. (b) Staff. The supervisory responsibility for dietetic services shall be assigned to one employee. (1) A dietetic services supervisor or licensed dietician shall provide scheduled on-site	S3290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3290	Continued From page 39 supervision in each facility with 11 or more residents. (2) 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 26-41-206(b)(2) The census equalled six the sample included three Residents. All Residents received meal service. Based on interviews and reviews of records, for two of three sampled (#185 and #189), the Administrator failed to ensure the provision or coordination of dietary services to Residents, and, failed to ensure physician ordered therapeutic diets prepared according to instructions from a medical care provider or licensed dietician. Findings included: - Review of record revealed #185 admitted to facility 9/21/15 with diagnoses of diabetes, dyspepsia, insomnia, hypertension, atrial fibrillation, depressive disorder, anxiety, osteoarthritiis, and gastroesophageal reflux disease. Current FCS of medical record dated 9/16/15. This FCS assessed #185 independent with eating. Section B.1.b. documented "diabetic" diet.	S3290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3290	Continued From page 40	S3290		

Current physician order sheet (POS) signed 4/18/18 directed "1800 calorie ADA (American Diabetes Association) diet."
The medical record lacked a negotiated service agreement.

- Review of record revealed #189 admitted to facility 5/11/12 with diagnoses of anxiety, depressive disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, gastroesophageal reflux disease, anemia, and osteoarthritiis.

Current functional capacity screen of 5/04/18 assessed #189 independent with eating.
Current physician order sheet (POS) signed 3/27/18 directed "Low Sodium diet."
Current 5/04/18 negotiated service agreement (NSA) documented "Regular" diet, and failed to include the physician ordered low sodium diet.

On 5/16/18 at 2:15pm director of nursing #F stated I know nothing regarding dietary instructions or what's served... skilled unit prepares and sends the meals back on food cart...

On 5/21/18 at 2:05pm administrator #D stated I will email a copy of the signed diet preparation directions for #185 (1800 calorie ADA) and for #189 (Low sodium).

On 5/22/18 at 3:41pm human resource (HR) staff #E confirmed administrator #D has scanned the documents... has not emailed them yet.

The Administrator failed to ensure the provision or coordination of dietary services to #189 and #185, and, failed to ensure physician ordered therapeutic diets prepared according to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3290	Continued From page 41 instructions from a medical care provider or licensed dietician.	S3290		
S3296 SS=F	26-41-206 (c) (1) Dietary Services Weekly Menu (c) (1) Menu plans shall be available to each resident on at least a weekly basis. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(c)(1) The census equalled six the sample included three Residents. All Residents received meal services. Based on observation, interviews and reviews of records, for three of three sampled (#189, #187, and #185) and all non-sampled, the Administrator failed to ensure weekly menu plans of foods served available to Residents. Findings included: - On 5/15/18 from 3:30pm to 6:45pm and on 5/16/18 from 9:00am to 10:35am, unable to locate seven day menus in the Assisted Living (AL) unit. During the entrance conference beginning at 3:30pm on 5/15/18 human resource (HR) staff #E stated the meals for AL are prepared in the skilled unit kitchen and transported back to AL on food carts. On 5/16/18 at 10:00am director of nursing #F stated I have no idea if menus are posted back here or where they would be posted. On 5/16/18 at 10:15am certified staff #C confirmed no menus posted in the AL unit...	S3296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N053001	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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
S3296	Continued From page 42 stated we do offer lists for dinner and supper that include the special of the day and alternatives available... the Residents choose and circle the items they want... On 5/16/18 at 10:35am certified staff #C returned from skilled unit with a seven day menu and posted the menu in AL. The Administrator failed to ensure weekly menu plans of foods served available to Residents.	S3296		