Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N024001	A. BUILDING: _____ B. WING _____	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 the licensure resurvey for the above named facility conducted on 08/25/22.	S 000		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104 (d) (3) (4) The census equaled 3 residents. The sample included 3 residents and review of 5 employee records. Based on record review and interview, Administrator/Licensed Nurse (LN) A failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of	S3280		

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
	N024001	A. BUILDING: _____ B. WING _____	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 1	S3280		

the facility's entire "Emergency Management Plan" with staff and residents and an annual emergency drill with staff and residents to include an evacuation of the residents to a secure location.

Findings included:

- Review of the facility "Emergency Management Plan" revealed the plan contained procedures to manage potential emergencies and disasters including fire, flood, severe weather, tornado, explosion, natural gas leak, lack of electrical, or water service, and missing residents.

The facility failed to provide documentation regarding emergency management plan reviews with residents.

The facility failed to provide documentation regarding emergency management plan reviews with staff for the second quarter of 2022.

Interview on 08/25/22 at 10:55 AM with Administrator/LN A confirmed no reviews were found with residents and further confirmed no annual emergency drill was conducted with all residents and staff that included an evacuation of all residents to a secure location.

Interview on 08/25/22 at 11:23 AM with Administrator/LN A stated disaster and emergency preparedness reviews with staff were completed annually, not quarterly, and confirmed no reviews were completed since 03/30/22 with staff.

Facility failed to provide a policy on disaster and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N024001	A. BUILDING: _____ B. WING _____	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 2 emergency preparedness reviews with staff and residents. Administrator/LN A failed to ensure disaster and emergency preparedness by the failure to ensure the performance of quarterly reviews of the facility's entire emergency plan with staff and residents and failed to conduct an annual emergency drill with staff and residents to include an evacuation of the residents to a secure location.	S3280		
S3310 SS=E	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: K.A.R 26-41-207 (c) The census totaled 3 residents. The sample included 3 residents and review of 5 newly hired	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N024001	A. BUILDING: _____ B. WING _____	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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
S3310	Continued From page 3	S3310		

employees. Based on record review and interview for 3 staff (Certified Nurse Aide (CNA) C, Facility Staff D and Facility Staff E, the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines.

Findings included:

- Review of CNA C's employee record revealed they hired onto the facility on 06/29/22. CNA C's record lacked evidence of TB testing and a TB questionnaire upon hire. CNA C's first step TB test and TB questionnaire were completed 08/12/22, approximately 6 weeks after being hired by the facility. Record lacked evidence of second step of TB testing.

Review of Facility Staff D employee record revealed they hired onto the facility on 04/19/22. Facility Staff D's record lacked evidence of TB testing and a TB questionnaire upon hire. Facility Staff D's first step TB test and TB questionnaire were completed on 06/08/22, approximately 7 weeks after being hired by the facility. Record lacked evidence of second step of TB testing.

Review of Facility Staff E's employee record revealed they hired onto the facility on 04/05/22. Facility Staff E's record lacked evidence of TB testing and a TB questionnaire upon hire. Facility Staff E's TB test was completed 06/01/22, approximately 8 weeks after being hired by the facility. Facility Staff E's TB questionnaire was completed 05/31/22, approximately 8 weeks after being hired by the facility.

Interview on 08/25/22 at 02:00 PM with Administrator/ Licensed Nurse (LN) A confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N024001	A. BUILDING: _____ B. WING _____	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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
S3310	Continued From page 4 CNA C, Facility Staff D and Facility Staff E did not receive TB testing or a TB questionnaire upon hire and were late. Facility failed to provide a TB policy. The facility failed to ensure compliance with the State Agency's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, which had the potential to affect all residents.	S3310		