STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006006	A. BUILDING: _____ B. WING _____	10/04/2022

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COUNTRY PLACE MEMORY CARE OF FORT SCOTT	822 S HORTON STREET FORT SCOTT, KS 66701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with a complaint #173179 and #166467 at the above named Home Plus conducted on 09/28/22, 09/29/22, 10/03/22 and 10/04/22.	S 000		
S5055 SS=F	26-42-101 (l) Survey Report l) Survey report and plan of correction. Each administrator or operator shall ensure that a copy of the most recent survey report and plan of correction is available in a common area to residents and any other individuals wishing to examine survey results. This REQUIREMENT is not met as evidenced by: KAR 26-42-101 (l) The facility reported a census of seven residents. Based on observation and interview the administrator failed to ensure a copy of the most recent survey report was made available in a common area for residents and any other individuals to examine. Findings included: - On 09/28/22 at 03:39 PM the "State Survey" notebook was located on a countertop in the kitchen with some other notebooks. The "State Survey" notebook did not have anything on the spine of the notebook to identify it as the "State Survey" notebook, so it was not easy to identify. The last survey included in the notebook was dated 09/23/2019 which was not the last survey completed.	S5055		

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

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S5055	Continued From page 1 On 09/29/22 at 08:45 AM an observation of a sign posted high on the wall next to the front entrance documented Policies and Procedures and State Survey Results were available in the commons area. The administrator failed to ensure a copy of the most recent survey results was available in a common area for residents and any other individuals wishing to examine them.	S5055		
S5105 SS=F	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus 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 26-42-202(a) The facility reported a census of seven residents	S5105		

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S5105	Continued From page 2	S5105		

with three residents included in the sample and one focused sample review. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed on what triggered in the "Functional Capacity Screen" (FCS) for Resident (R)128, R129, R130 and R131.

Findings included:

- R128's medical record revealed the resident moved into the facility on 08/06/19 with a diagnosis of dementia.

The 09/06/21 FCS identified R128 triggered for falls/unsteadiness, impaired decision-making, and wandering.

The 09/06/21 NSA did not address R128's falls/unsteadiness, impaired decision-making, and wandering.

On 10/03/22 at 12:55 PM Administrative Nurse B stated if items trigger on the FCS they should be addressed on the NSA.

The administrator failed to ensure R128's NSA was fully developed to include all items that triggered in the FCS.

- R129's medical record revealed the resident moved into the facility on 04/16/21 with a diagnosis of dementia.

The 08/03/22 FCS identified R129 triggered for falls/unsteadiness, impaired decision-making, and wandering.

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S5105	Continued From page 3 The 08/05/22 NSA did not address R129's triggers for falls/unsteadiness, impaired decision-making, and wandering. On 10/03/22 at 12:55 PM Administrative Nurse B stated if items trigger on the FCS they should be addressed on the NSA. The administrator failed to ensure R129's NSA was fully developed to include all items that triggered in the FCS. -R130's medical record revealed the resident moved into the facility on 06/11/18 with a diagnosis of dementia. The 06/08/22 FCS identified R130 triggered for fall/unsteadiness and impaired decision-making and wandering. The 08/09/22 NSA did not address R130's impaired cognition and triggers for falls/unsteadiness and impaired decision-making. On 10/03/22 at 12:55 PM Administrative Nurse B stated if items trigger on the FCS they should be addressed on the NSA. The administrator failed to ensure R130's NSA was fully developed to include all items that triggered in the FCS. -R131's medical record revealed the resident moved into the facility on 06/11/18 with a diagnosis of dementia. The 07/28/22 FCS identified R131 triggered for	S5105		

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S5105	Continued From page 4 wandering. The 07/30/22 NSA did not address R131's wandering. On 10/03/22 at 12:55 PM Administrative Nurse B stated if items trigger on the FCS they should be addressed on the NSA. The administrator failed to ensure R131's NSA was fully developed to include all items that triggered in the FCS.	S5105		
S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (f) The facility had a census of seven residents. All seven residents ate food prepared in the same kitchen. The administrator failed to ensure food items were stored under safe and sanitary conditions by the failure to ensure foods stored in the refrigerators were kept at 41 degrees Fahrenheit (F) or lower according to Food Safety Guidelines and failed to ensure food items were properly dated.	S5195		

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S5195	Continued From page 5 Findings included: - Observation on 09/28/22 at 03:41 PM revealed a "Refrigerator/Freezer Temperature Log Sheet" posted on the side of the refrigerator/freezer unit in the kitchen. This log sheet did not identify what month it was for and had only two days which had temperatures logged. Inspection of the refrigerator revealed the following items were not labelled or dated: A plastic storage bag of yellow shredded cheese. Two plastic pitchers of drinks. Inspection of the freezer revealed the following items were not labelled or dated: Two plastic storage bags of what appeared to be hash brown potatoes. One package of what appeared to be a "hot pocket" not in its original packaging. The 2007 "Food Services" policy documented, "All perishable food stored in the refrigerator is to be covered, dated in containers ...The kitchen staff will be responsible for maintaining the kitchen logs. First shift employees will log refrigerator/freezer temperatures ..." According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, "Cold foods must be maintained at an internal temperature of 41F or below." "Date mark foods appropriately, cover foods after completely cooled, cover foods to maintain cold holding temperature." The operator failed to ensure food items were stored under safe and sanitary conditions by	S5195		

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S5195	Continued From page 6 failing to document refrigerator/freezer temperatures and ensure food items were dated.	S5195		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-207(c) The facility reported a census of seven residents. Based on interview and record review for three residents and five new employee records, the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105. Findings included: - Review of five newly hired staff records revealed the following:	S5230		

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S5230	Continued From page 7 Certified Medication Aide (CMA) E's employee record revealed a hire date of 01/07/22. The facility failed to ensure a two-step TB skin test was started within seven days of employment. Certified Nurse Aide (CNA) F's employee record revealed a hire date of 11/18/21. The facility failed to ensure the second step of the two-step TB skin test was administered 1-3 weeks after the first step was completed. CNA G's employee record revealed a hire date of 09/25/21. The facility failed to ensure a TB screening questionnaire was completed within seven days of hire, failed to ensure the first step of the two-step TB skin test was administered within seven days of hire and failed to ensure the second step of the TB skin test was administered 1-3 weeks after the first step was completed. CNA H's employee record revealed a hire date of 10/12/21. The facility failed to ensure a TB screening questionnaire was completed within seven days of hire and failed to ensure the second step of the TB skin test was administered 1-3 weeks after the first step was completed. Temporary Nurse Aide (TNA) H's employee record revealed a hire date of 05/03/22. The facility failed to ensure a TB screening questionnaire and the first step of the two-step TB skin test was administered within seven days of employment. On 10/04/22 at 03:12 PM Administrative Staff A stated she expected two-step TB skin tests and TB Screening Questionnaires to be completed	S5230		

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S5230	Continued From page 8 upon hire. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident and new employee shall have an initial TB symptom screen that includes the components of the TB symptom questionnaire within seven days of residency or employment." The 2014 "TB Skin Tests" policy documented, "Each new resident and employee shall begin a two-step tuberculin skin test ...within seven days of residency or employment ...If the first skin test is read as not positive, a second skin test shall be administered within 1 to 3 weeks." The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105 regarding newly hired employees. - Resident (R)129 moved into the facility on 04/16/21 with a diagnosis of dementia. R129's medical record revealed an annual tuberculosis (TB) symptom screening questionnaire was not completed for 2022. On 10/03/22 at 12:55 PM Administrative Nurse B confirmed she had not completed an annual TB screening questionnaire for R129 for 2022. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each resident ...shall have an annual TB symptom screen ..." The administrator failed to ensure compliance	S5230		

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S5230	Continued From page 9 with the department's TB guidelines for adult care homes adopted by reference to K.A.R. 26-29-105.	S5230		
S5251 SS=D	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of seven residents with three residents included in the sample and one focused sample review. Based on interview, and record review the operator failed to ensure staff documented in Resident (R)129's medical record an incident where R129 was on the floor of the memory care unit from approximately 01:30 AM to 05:00 AM on 10/07/21. Findings included: - R129's medical record revealed the resident moved into the facility on 04/16/21 with a diagnosis of dementia. The 08/03/22 FCS identified R129 triggered for falls/unsteadiness, impaired decision-making, and wandering.	S5251		

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S5251	Continued From page 10 Review of R129's medical record failed to locate any documentation in nursing notes, physician notifications, family notifications, etc. of an incident that took place on or around 10/07/21 when R129 was on the floor from approximately 01:30 AM to 05:00 AM. On 10/06/22 at approximately 09:30 AM Administrative Staff A emailed information concerning the above-mentioned incident which included the following documentation: On 10/07/21 Certified Nurse Aide (CNA) L documented the CNA on duty in the adjacent memory care unit called senior living staff to help with resident rounds and noted R129 was on the floor at 02:00 AM when CNA L arrived at the memory care unit. An email dated 10/08/21 from Certified Medication Aide (CMA) J documented senior living staff went to the memory care unit at approximately 04:00 AM to assist with getting R129 off the floor and into her bed. An "Incident Report" dated 10/07/21 by CNA K documented R129 was on the floor in the memory care unit from approximately 01:30 AM to 05:00 AM. On 10/04/22 at 09:42 AM CMA D stated they were aware of the fact that R129 was on the floor for in the memory care unit for approximately four hours on the morning of 10/07/21 and stated this incident was reported to administrative staff. On 10/03/22 at 02:09 PM Administrative Staff A stated she did not know R129 had a fall on	S5251		

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S5251	Continued From page 11 10/07/21. Administrative Staff A stated she worked as a CMA at the time in the senior living center. The administrator failed to ensure staff documented all incidents in R129's medical record.	S5251		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced by:	S5258		

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S5258	Continued From page 12 KAR 26-42-102(d)(1) The facility reported a census of seven residents. Based on interview and record review, the administrator failed to ensure three of five newly hired employee records included evidence verification with the nurse aide registry was completed prior to staff employment. Findings included: - Review of employee files conducted on 09/29/22 revealed the following: Certified Medication Aide (CMA) E hired on 01/07/22. The date on the "Nurse Aide Registry Confirmation Notice" indicated the facility completed a registry check six days after the date of hire. Certified Nurse Aide (CNA) F hired on 11/18/21. The "Nurse Aide Registry Confirmation Notice" indicated the facility completed a registry check 13 days after the date of hire. CNA G hired on 09/25/21. The "Nurse Aide Registry Confirmation Notice" indicated the facility completed a registry check five days after the date of hire. On 10/04/22 at 03:09 PM Administrative Staff A stated she expected the nurse aide registry to be checked for staff certification prior to being hired. The undated facility document "New Employee Procedures" documented, "Before offering the job, check the Nurse Aide Registry web site for certificate verification."	S5258		

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S5258	Continued From page 13 The administrator failed to ensure verification of the nurse aide registry checks were completed prior to staff employment.	S5258		
S5313 SS=F	26-42-205 (g) (3) Over the counter medication (g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (g)(3) The facility reported a census of seven residents. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of over-the-counter medications for four residents. A total of eight containers of medications were not labeled. Findings included:	S5313		

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COUNTRY PLACE MEMORY CARE OF FORT SCOTT	822 S HORTON STREET FORT SCOTT, KS 66701

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S5313	Continued From page 14 - Observation on 09/28/22 at 04:31 PM revealed the medication room contained the following over-the counter medications which were not labeled with the resident's full name: For Resident (R) 132: A bottle of Stool Softener and Stimulant Laxative with no name. A bottle of Equate Ibuprofen (pain) capsules 200 milligrams (mg) with no name. A bottle of Spring Valley Omega-3 (supplement) 1000 mg with no name. For R129: A four fluid ounce bottle of Children's Dye-Free Pain & Fever with no name. For R133: A bottle of Nature's Bounty Fish Oil (supplement) 1000 mg with only the first name and last initial written on the bottle. For R131: A bottle of Bone Minis (supplement) with only a first name written on the bottle. For R134: A bottle of Equate Complete Multivitamin (supplement) with only the first name and last initial written on the bottle. A bottle of Rugby Aspirin (pain/fever) 81 mg with no name. On 10/04/22 at 03:10 PM Administrative Staff A stated she expected all over-the-counter medications belonging to residents to be labeled with the resident's full name.	S5313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006006	A. BUILDING: _____ B. WING _____	10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5313	Continued From page 15 The 2015 "Medication Management" policy documented, "Medication boxes are labeled with the resident's name ..." The administrator failed to ensure all over-the-counter medications were labeled with the resident's full name.	S5313		