STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VALHLTHCLOSE	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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 represent the findings of a resurvey for the above named Residential Health Care facility conducted on 01/30/23 and 01/31/23.	S 000		
S3085 SS=E	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)(1)(2) The facility reported a census of seven residents with three residents included in the sample. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed on what	S3085		

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
	VALHLTHCLOSE	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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 1	S3085		

triggered in the "Functional Capacity Screen" (FCS) for Resident (R)101, R102, and R103.

Findings included:

- R101's medical record revealed the resident moved into the facility on 12/01/19 with a diagnosis of paranoid schizophrenia.

The 01/13/23 FCS identified R101 needed supervision with bathing, required physical assist with medications and treatments, had impaired vision, impaired hearing, impaired decision-making and inappropriate behavior.

The 01/20/23 NSA did not address bathing, management of medications and treatments, impaired vision, impaired hearing, impaired decision-making and inappropriate behavior.

On 01/31/23 at 12:31 PM Administrative Nurse H stated if the FCS triggered for anything this should be addressed on the NSA.

The undated "Negotiated Service Agreement" policy documented, "The NSA shall provide the following information: A description of the services the resident will receive."

The operator failed to ensure R101's NSA was fully developed to include all items that triggered on the FCS.

- R102's medical record revealed the resident moved into the facility on 10/15/21 with a diagnosis of paranoid schizophrenia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VALHLTHCLOSE	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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 2	S3085		

The 01/11/23 FCS identified R102 required supervision with bathing, physical assistance with management of medications and treatments, and triggered for falls, impaired hearing, impaired decision-making and inappropriate behavior.

The 01/18/23 NSA did not address bathing, management of medications and treatments, falls, impaired hearing, impaired decision-making and inappropriate behavior.

On 01/31/23 at 12:41 PM Administrative Nurse H stated if the FCS triggered for anything this should be addressed on the NSA.

The undated "Negotiated Service Agreement" policy documented, "The NSA shall provide the following information: A description of the services the resident will receive."

The operator failed to ensure R102's NSA was fully developed to include all items that triggered on the FCS.

-R103's medical record revealed the resident moved into the facility on 06/01/05 with a diagnosis of schizophrenia.

The 01/10/23 FCS identified R103 required supervision with bathing, physical assistance with management of medications and treatments. Cognition triggered for impaired decision-making and triggered for inappropriate behavior.

The 01/17/23 NSA did not address bathing, medications and treatments, cognition, impaired decision-making and inappropriate behavior.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VALHLTHCLOSE	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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 3 On 01/31/23 at 12:43 PM Administrative Nurse H stated if the FCS triggered for anything this should be addressed on the NSA. The undated "Negotiated Service Agreement" policy documented, "The NSA shall provide the following information: A description of the services the resident will receive." The operator failed to ensure R103's NSA was fully developed to include all items that triggered on the FCS.	S3085		
S3270 SS=F	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)(6)(8) The facility reported a census of seven residents.	S3270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VALHLTHCLOSE	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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 4 Based on record review and interview for all residents and all facility employees, the operator failed to ensure the disaster and emergency plan include all required items as it failed to include information on flood, explosion, natural gas leak, lack of electricity or water service, and missing resident. Findings included: - On 01/31/23 review of documentation of the emergency management plan revealed it did not include information concerning flood, explosion, natural gas leak, lack of electricity or water service, and missing resident. On 01/31/23 at 11:27 AM Administrative Staff B acknowledged the emergency management plan did not include all the required items. The operator failed to ensure the emergency management plan included all the required items.	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 admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VALHLTHCLOSE	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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 5	S3280		

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 facility reported a census of seven residents. Based on record review and interview for all residents and all facility employees, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with employees and residents.

Findings included:

- A request was made on 01/31/23 to see documentation of quarter reviews of the emergency management plan with staff and residents.

On 01/31/23 at 11:27 AM Administrative Staff B stated prior to January 2023 the facility did not review the emergency management plan with all staff and residents on a quarterly basis.

The operator failed to ensure the performance of quarterly reviews of the emergency management plan with employees and residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VALHLTHCLOSE	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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 SS=F	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: KAR 26-41-207(c) The facility reported a census of seven residents. Based on record review and interview the operator failed to ensure the facility was in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings include: - Review of five newly hired staff records revealed the following: Certified Nurse Aide (CNA) C hired on 09/15/22 did not have a TB symptom screening questionnaire or a two-step Skin Test (TST)	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VALHLTHCLOSE	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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 7 completed upon hire. CNA D hired on 08/23/22 had a TB symptom screening questionnaire completed 53 days late and did not have a two-step TST completed upon hire. CNA E hired on 12/17/22 did not have a two-step TST completed upon hire. CNA F hired on 07/28/22 did not have a two-step TST completed upon hire. CNA G hired on 01/03/22 had the first step of the two-step TST administered two days late and had the second step of the TST administered two days early. On 01/31/23 at 12:45 PM Administrative Staff A stated she was aware there were some issues with TB symptom screening questionnaires and two-step TSTs not being completed for newly hired staff. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new ...employee shall have an initial TB symptom screen that includes the components of the TB symptom questionnaire within 7 days of ...employment. Each new ...employee shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of employment..." The operator failed to ensure the compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VALHLTHCLOSE	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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