STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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 02/20/23 - 02/21/23.	S 000		
S 110 SS=F	26-39-103 (c) NOTICE OF RIGHTS AND SERVICES (c) Notice of rights and services. (1) Before admission, the administrator or operator shall ensure that each resident or the resident's legal representative is informed, both orally and in writing, of the following in a language the resident or the resident ' s legal representative understands: (A) The rights of the resident; (B) the rules governing resident conduct and responsibility; (C) the current rate for the level of care and services to be provided; and (D) if applicable, any additional fees that will be charged for optional services. (2) The administrator or operator shall ensure that each resident or the resident ' s legal representative is notified in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care. This STANDARD is not met as evidenced by: KAR 26-39-103(c)(1)(B) The facility reported a census of 31 residents. Based on interview and record review the	S 110		

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
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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 110	Continued From page 1 operator failed to ensure resident (R)101, R102 and R103 were informed, both orally and in writing of the rules governing resident conduct and responsibility. Findings included: - R101 was admitted to the facility on 01/16/20. Review of R101's medical records failed to locate documentation that he was informed of the rules governing resident conduct and responsibility. On 02/21/23 at 01:57 PM Administrative Nurse A stated she did not have any rules governing resident conduct and responsibility to inform the residents of. The operator failed to ensure R101 was informed of the rules governing resident conduct and responsibility. - R102 was admitted to the facility on 09/06/22. Review of R102's medical records failed to locate documentation that he was informed of the rules governing resident conduct and responsibility. On 02/21/23 at 01:57 PM Administrative Nurse A stated she did not have any rules governing resident conduct and responsibility to inform the residents of. The operator failed to ensure R102 was informed of the rules governing resident conduct and responsibility.	S 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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 110	Continued From page 2 - R103 was admitted to the facility on 04/05/22. Review of R103's medical records failed to locate documentation that he was informed of the rules governing resident conduct and responsibility. On 02/21/23 at 01:57 PM Administrative Nurse A stated she did not have any rules governing resident conduct and responsibility to inform the residents of. The operator failed to ensure R103 was informed of the rules governing resident conduct and responsibility.	S 110		
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.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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 This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1)(2) The facility reported a census of 31residents 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 triggered in the "Functional Capacity Screen" (FCS) for resident (R)102, and R103. Findings included: - R102's medical record revealed the resident moved into the facility on 09/06/22. The 09/06/22 FCS identified R102 triggered for impaired vision and impaired hearing. The 09/06/22 NSA did not address impaired vision and impaired hearing. On 02/21/23 at 04:01 PM Administrative Nurse A stated impaired hearing and impaired vision were not addressed on R102's NSA. The 01/14/15 "Functional Capacity Screen & Negotiated Service Agreement" policy documented, "The Functional Capacity Screen shall be used as a basis for determining the services to be included in the Negotiated Service Agreement." The operator failed to ensure R102's NSA was fully developed to include all items that triggered on the FCS.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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 4 - R103's medical record revealed she moved into the facility on 04/05/22. The 06/16/22 FCS identified R103 as having triggered for falls, unsteadiness. The 06/16/22 NSA did not address falls, unsteadiness. On 02/21/23 at 03:54 PM Administrative Nurse A stated anything that triggered on the FCS should be addressed on the NSA and acknowledge the NSA did not address falls, unsteadiness. The 01/14/15 "Functional Capacity Screen & Negotiated Service Agreement" policy documented, "The Functional Capacity Screen shall be used as a basis for determining the services to be included in the Negotiated Service Agreement." The operator failed to ensure R103's NSA was fully developed to include all items that triggered on the FCS.	S3085		
S3200 SS=F	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
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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 5 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) The facility reported a census of 31 residents. Based on observation and interview, the operator failed to ensure that all medications were administered within professional standards of practice. The Certified Medication Aide (CMA) pre-popped medications into medication cups for administration to residents at a future time and failed to follow professional standards of practice designed to safeguard each resident. Findings included: - On 02/20/23 at 03:51 PM observation of multiple clear plastic medication cups labelled with residents last name where stored in a cabinet underneath the sink in the medication room. On 02/20/23 at 03:54 PM CMA B stated the pre-popped pills were for the evening medication administration. CMA B stated she usually pre-popped the resident medications into pill	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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 6 cups labelled with the resident's name. The February 2011 Kansas Certified Medication Curriculum page 165 documented, "All medications must be identified to point of administration. For medications removed from a package or container with the prescription label, a medication card must be used which contains the resident's name, the name of the medication, the route of administration, special instructions for administration and time of administration. This card must be checked against the MAR before administering the medication to a resident." On 02/20/23 a policy for medication administration was requested but Administrative Nurse A stated she did not have a policy for this. The operator failed to ensure staff followed professional standards of practice designed to safeguard each resident when administering medications.	S3200		
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 management plan with employees and residents;	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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 7 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) The facility reported a census of 31 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 all residents. Findings included: - On 02/21/23 Administrative Nurse Staff A provided documentation of meetings held with residents to include review of the emergency policies. Review of this documentation revealed that not all of the facility's residents were present during these meetings. On 02/21/23 at approximately 04:30 PM Administrative Nurse A acknowledged not all of the facility residents were included on the documentation of the quarterly review of the emergency management plan. The operator failed to ensure the performance of	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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 8 quarterly reviews of the emergency management plan with all residents.	S3280		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (d) The facility had a census of 31 residents. All 31 residents ate food prepared in the same kitchen. The operator failed to ensure food items were served at the proper temperature. Findings included:	S3298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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
S3298	Continued From page 9 - On 02/20/23 at 04:10 PM observation of the food menus with food temperatures documented dated between 01/01/23 through 02/17/23 revealed numerous days where no food temperatures were documented or days where only some food temperatures were documented. On 02/22/23 at 02:20 PM Administrative Nurse A stated the facility did not have a policy for food temperatures. Administrative Nurse A stated she had verbally went over taking food temps with staff but they were not documented. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, hot foods must be maintained at an internal temperature of 135 Fahrenheit (F) or higher and cold foods must be maintained at an internal temperature of 41 F or below. The operator failed to ensure food items were served at the proper temperature.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (e)	S3299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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
S3299	Continued From page 10 The facility had a census of 31 residents. All 31 residents ate food prepared in the same facility kitchen. The operator failed to ensure food items were stored under safe and sanitary conditions by the failure to document temperatures of food items stored in the refrigerator/freezer were at acceptable temperatures according to food safety guidelines. Findings included: - Observation on 02/20/23 at 04:10 PM revealed there was no documentation of refrigerator/freezer temperatures documented by staff. On 02/20/23 at 04:40 PM Administrative Nurse A stated there were thermometers in all refrigerators/freezers but there were no temperature logs for the staff to log temperatures down. A policy concerning food storage was requested on 02/20/23 but the facility did not have one. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017 the "Temperature DANGER ZONE is from 41 F to 135 F, the range in which rapid growth occurs." The operator failed to ensure food items were stored under safe and sanitary conditions.	S3299		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each	S3305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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
S3305	Continued From page 11 assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (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 (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by:	S3305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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
S3305	Continued From page 12 KAR 26-41-207 (b)(4) The facility had a census of 31 residents. All 31 residents ate food prepared in the same kitchen. The operator failed to ensure sanitary conditions for food service by not monitoring dishwashing temperatures or chemical sanitization levels. Findings included: - Observation on 02/20/23 at 04:10 PM revealed there was no documentation of hot water temperature or chemical strength for the dishwashing machine. On 02/21/23 at 04:33 PM Administrative Nurse A stated staff did not monitor hot water temperatures or the chemical strength for the dishwashing machine. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, chemical sanitization required 50-200 parts per million (ppm) of chlorine or 200 ppm quaternary ammonia. For hot water temperature sanitization, the temperature must be at least 180 degrees Fahrenheit (F). The operator failed to ensure dishwashing sanitization was monitored for and documented.	S3305		
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	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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 13 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 31 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 Medication Aide (C) hired 09/24/21 did not have a TB symptom screening questionnaire completed upon hire. The first step of the "tuberculosis skin test" (TST) was read on 08/26/21. The second step of the two-step TST was administered on 09/22/21 six days late. Certified Nurse Aide (CNA) D hired 04/08/22 did not have a TB symptom screening questionnaire completed upon hire.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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 14 CNA E hired 07/13/22 did not have a TB symptom screening questionnaire completed upon hire. CNA F hired on 06/02/21 did not have a TB symptom screening questionnaire completed upon hire. CMA G hired on 09/21/21 did not have a TB symptom screening questionnaire completed upon hire. On 02/21/23 at 03:52 PM AM Administrative Nurse A stated the facility did not complete TB screening questionnaires with 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 ...If the first TST is read as not positive, a second TST shall be administered within 1 to 3 weeks." 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. - Resident (R)102 admitted to the facility on 09/06/22. Review of R102's medical records revealed he did not have a two-step TST completed upon admission.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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 15 On 02/21/23 at 04:01 PM Administrative Nurse A stated R102 transferred from another facility, and she used his TB information from that facility instead of initiating a two-step TST when he admitted. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall receive a two-step TST ...within 7 days of residency ...unless one of the following conditions is met: ...The new resident ...provide satisfactory documentation of receiving the two-step TST ...within 6 months prior to residency ...that read not positive." 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. - R103 admitted to the facility on 04/05/22. Review of the medical records revealed R103 did not have a TB symptom screening questionnaire completed upon admission. On 02/21/23 at 01:57 PM Administrative Nurse A stated they did not complete a TB screening questionnaire for R103 when she first admitted to the facility. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall have an initial TB symptom screen that includes the components of the TB Symptom Screen Questionnaire within 7 days of residency."	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

(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 16 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		