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| | B081003 | A. BUILDING: _____ B. WING _____ | 08/08/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| FOUNDATION PARK 4915 | 4915 COLBERT HILLS DR MANHATTAN, KS 66503 |

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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a resurvey at the above named home plus facility conducted on 08/08/23. | S 000 | | |
| S5171 SS=D | 26-42-204 (i) Health Care Services Standards of Practice<br><br>(i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-204 (i)<br><br>The census totaled 4 residents. The sample included 3 residents. Based on observation, interview and record review, Administrator/ Licensed Nurse (LN) A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice for the use of bed assistive devices, which met the needs of 1 of 3 sampled residents (R)1.<br><br>Findings included:<br><br>- The "Resident Roster" obtained on 08/08/23 identified one resident as having a bed assistive device.<br><br>Record review for R1 revealed he admitted to the facility on 06/07/23 with diagnoses of Parkinson's disease, hypertension, arthritis, Dementia and major depressive disorder. | S5171 | | |

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

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| S5171 | Continued From page 1<br><br>R1's current "Functional Capacity Screen" (FCS) dated 06/07/23 recorded the resident as independent with toileting, walk/mobility and eating, supervision required for transfer, physical assistance required for bathing and dressing, and was unable to perform management of medications and treatments. The FCS recorded R1 was occasionally incontinent, had impaired short and long-term memory, memory/recall impaired, impaired decision-making skills and usually understandable/ usually understood. R1 had impaired vision and had socially inappropriate disruptive behavior.<br><br>The resident's "Negotiated Service Agreement" (NSA) dated 06/05/23 recorded bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments were supervised nursing services provided by facility. The NSA failed to identify the use of a bed assistive device.<br><br>The resident's "Service Plan" dated 06/15/23 recorded facility staff assisted R1 with bathing, dressing and management of medications and treatments. The "Service Plan" recorded R1 was independent with toileting, transfer and walk/mobility.<br><br>Record review lacked an annual assessment of the resident to confirm the device was not a restraint, an assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment. | S5171 | | |

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| S5171 | Continued From page 2<br><br>Observation on 08/08/23 at 01:45 PM of R1's room revealed a bed assist device to the right side of the bed.<br><br>Interview on 08/08/23 at 02:30 PM with Administrator/ LN A confirmed no safety checks or bed assistive device assessments completed on R1 since 06/07/23 admission.<br><br>The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows:<br>Zone 1 within the rail should measure less than 4 and 3/4 inches<br>Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches<br>Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches<br>Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches.<br><br>Administrator/ LN A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice which met the needs of R1 regarding use of a bed assistive device. | S5171 | | |
| S5192 SS=F | 26-42-206 (e) Food Preparation<br><br>(e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper | S5192 | | |

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| S5192 | Continued From page 3<br>temperature.<br>(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.<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-206 (e)<br><br>The census equaled 4 residents. Based on record review, interview and observation for all residents living in the facility and receiving meal services, Administrator/ Licensed Nurse (LN) A failed to ensure facility staff served food at the proper temperature.<br><br>Findings included:<br><br>- During the initial tour on 08/08/23 at 11:10 AM, surveyor requested facility food temperature monitoring logs for August 2023 and the facility failed to provide food temperature monitoring logs.<br><br>Interview on 08/08/23 at 11:10 AM with Administrator/ LN A confirmed food temperatures were not recorded at each meal and further | S5192 | | |

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| S5192 | Continued From page 4<br>confirmed no record of food temperature monitoring logs.<br><br>Observation on 08/08/23 at 12:00 PM revealed 3 of 4 residents eating lunch time meal in the facility.<br><br>"Kansas Department of Agriculture Food Safety Guidelines" records hot food must be maintained at a temperature of 135 degrees Fahrenheit or above, cold foods at 41 degrees Fahrenheit or below.<br><br>Facility's "Dietary Services Policy and Procedures" policy dated 08/09/23 recorded, "7. Food will be prepared by facility staff using safe methods that conserve the nutritive value, flavor and appearance and shall be served at the proper temperature."<br><br>For all residents of the facility, Administrator / LN A failed to ensure facility staff served food at the proper temperature. | S5192 | | |
| S5195 SS=F | 26-42-206 (f) (g) Facility Food Storage<br><br>(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.<br>(g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus.<br><br>This REQUIREMENT is not met as evidenced by: | S5195 | | |

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| S5195 | Continued From page 5<br>KAR 26-42-206 (f)<br><br>The census equaled 4 residents. The sample included 3 residents. Based on record review, interview and observation for all residents receiving meal services, Administrator/ Licensed Nurse (LN) A failed to ensure the facility staff stored all food under safe and sanitary conditions.<br><br>Findings included:<br><br>- Observation during the initial tour on 08/08/23 at 11:10 AM revealed a kitchen containing food/drinks.<br><br>Observation of the refrigerator/freezer revealed no temperature monitoring logs.<br><br>Observation of the refrigerator revealed the following food items, which were not sealed: one blueberry pie, one package of butter, one package of cream cheese and one bowl of hard-boiled eggs.<br><br>Observation of the freezer revealed the following food items, which were not sealed or labeled: one bag of chicken, one bag of sausage, one bag of biscuits.<br><br>Observation of the pantry in the kitchen revealed the following food items, which were not sealed: one bag of sugar and one bag of flour.<br><br>Observation on 08/08/23 at 12:00 PM revealed 3 of 4 residents eating lunch time meal in the facility. | S5195 | | |

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| S5195 | Continued From page 6<br><br>Interview on 08/08/23 at 11:10 AM with Administrator/ LN A confirmed refrigerator/ freezer temperature monitoring logs were not recorded and further confirmed the above listed food items were not sealed or labeled.<br><br>Facility's "Dietary Services Policy and Procedures" policy dated 08/09/23 recorded, "6. Food will be stored under safe and sanitary conditions."<br><br>For all residents of the facility, Administrator/ LN A failed to ensure the facility staff stored all food under safe and sanitary conditions. | S5195 | | |
| S5215 SS=E | 26-42-104 (d) Disaster and Emergency Preparedness Education<br><br>(d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following:<br>(1) Orientation of new employees at the time of employment to the home ' s emergency management plan;<br>(2) education of each resident upon admission to the home regarding emergency procedures;<br>(3) quarterly review of the home ' s emergency management plan with employees and residents; and<br>(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.<br><br>This REQUIREMENT is not met as evidenced by: | S5215 | | |

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| S5215 | Continued From page 7<br>KAR 26-42-104 (d) (3)<br><br>The census equaled 4 residents. The sample included 3 residents and review of 3 newly hired 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 the facility's entire "Emergency Management Plan" with staff.<br><br>Findings included:<br><br>- 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.<br><br>On 08/08/23, surveyor requested the facility's quarterly reviews of the emergency management plan with staff and facility failed to provide documentation.<br><br>Interview on 08/08/23 at 09:42 AM with Operator/ LN A confirmed no quarterly reviews of the emergency management plan with staff were completed.<br><br>Facility's "Disaster Procedures Emergency Management Policy and Procedures" recorded, "All new employees of Foundation Park Home Plus receiving training on disaster and emergency preparedness policies and procedures as part of new employee orientation, reviewed quarterly and annually thereafter." | S5215 | | |

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|---|---|
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| S5215 | Continued From page 8<br>Administrator/LN A failed to ensure disaster and emergency preparedness by the failure to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's entire "Emergency Management Plan" with staff. | S5215 | | |
| S5230 SS=F | 26-42-207 (b)(5)(6) (c) Infection Control Policies<br><br>(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;<br>(6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting;<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-207 (c)<br><br>The census totaled 4 residents. The sample included 3 residents and review of 3 newly hired employees. Based on record review and interview for 3 sampled Residents (R)1, R2 and R3 and 3 newly hired employees (Certified Medication Aide (CMA) C, CMA D, CMA E, the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines. | S5230 | | |

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|---|---|
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| S5230 | Continued From page 9<br><br>Findings included:<br><br>- R1's "Medical Record" revealed he admitted to the facility on 06/07/23 and the record lacked completion of TB testing and a TB questionnaire upon admission.<br><br>R2's "Medical Record" revealed she admitted to the facility on 05/04/23 and the record lacked completion of TB testing and a TB questionnaire upon admission.<br><br>R3's "Medical Record" revealed she admitted to the facility on 01/30/23 and the record lacked completion of TB testing and a TB questionnaire upon admission.<br><br>- Review of CMA C's employee record revealed they hired onto the facility on 07/06/23. CMA C's record lacked evidence of completion of TB testing upon hire.<br><br>Review of CMA D's employee record revealed they hired onto the facility on 01/24/23. CMA D's record lacked evidence of completion of TB testing upon hire.<br><br>Review of CMA E's employee record revealed they hired onto the facility on 02/10/23. CMA E's record lacked evidence of completion of TB testing upon hire.<br><br>Interview on 08/08/23 at 01:16 PM with Administrator/Licensed Nurse (LN) A confirmed TB testing and a TB questionnaire was not completed upon admission for R1, R2 and R3. | S5230 | | |

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| S5230 | Continued From page 10<br><br>Interview on 08/08/23 at 02:13 PM with Administrator/LN A confirmed TB testing was not completed upon hire for CMA C, CMA D and CMA E.<br><br>Facility's "Assisted Living Tuberculosis Screening/ Testing Policy- Residents" dated 02/01/23 recorded, "Facility TB testing guidelines consists of the following: Testing will be performed on each new resident within three months prior to admission or within one week following admission to the facility."<br><br>Facility failed to provide a policy on TB testing for staff.<br><br>The facility failed to follow 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. | S5230 | | |
| S5250 SS=D | 26-42-105 (f) (1 - 10) Resident Records Content<br><br>(f) Each resident record shall contain at least the following:<br>(1) The resident's name;<br>(2) the dates of admission and discharge;<br>(3) the admission agreement and any amendments;<br>(4) the functional capacity screenings;<br>(5) the health care service plan, if applicable;<br>(6) the negotiated service agreement and any revisions;<br>(7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency;<br>(8) the name, address, and telephone number of | S5250 | | |

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| S5250 | Continued From page 11<br>the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition;<br>(9) the name, address, and telephone number of the case manager, if applicable;<br>(10) records of medications, biologicals, and treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-105 (f) (3)<br><br>The facility reported a census of 4 residents. The sample included 3 residents. Based on record review and interview for 1 of 3 sampled Residents (R)2, Administrator/Licensed Nurse (LN) A failed to ensure the resident's record contained the admission agreement and any amendments thereto.<br><br>Findings included:<br><br>Record review for R2 revealed she admitted to the facility on 05/04/23 with diagnoses of Parkinson's disease.<br><br>Admission agreement requested on 08/08/23 and Administrator/ LN A stated unable to locate admission agreement.<br><br>Facility's "Assisted Living Admission Agreement" policy dated 08/09/23 recorded, "Procedure: Prior to admission, or on admission, the Administrator/Operator meets with the resident | S5250 | | |

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| S5250 | Continued From page 12<br>and/or representative to discuss the agreement as well as all fees and the Negotiated Service Agreement. The admission agreement must be signed prior to, or day of admission."<br><br>Administrator/ LN A failed to ensure the resident's record contained the admission agreement and any amendments thereto. | S5250 | | |
| S5258 SS=D | 26-42-102 (d) Staff Qualifications Employee Records<br><br>(d) The employee records and agency staff records shall contain the following information:<br>(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;<br>(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;<br>(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<br>(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.<br><br>This REQUIREMENT is not met as evidenced | S5258 | | |

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| S5258 | Continued From page 13<br>by:<br>KAR 26-42-102 (d) (2)<br><br>The facility census equaled 4 residents. The sample included 3 residents and record review of 3 newly hired employees. Based on interview and personnel record review for 1 (Certified Medication Aide (CMA) C) of 3 staff sampled, Administrator/ Licensed Nurse (LN) A failed to obtain evidence of supporting documentation for criminal background checks when the background checks were not conducted through the Kansas Department for Aging and Disability Services according to K.S.A 39-970 (d).<br><br>Findings included:<br><br>- On 08/08/23, personnel record review for staff revealed the following:<br><br>Certified staff C hire date 07/06/23, no evidence of criminal background check completed through the Kansas Department for Aging and Disability Services according to K.S.A 39-970 (d).<br><br>Interview on 08/08/23 with Administrator/LN A confirmed criminal background check was not completed through the Kansas Department for Aging and Disability Services according to K.S.A 39-970 (d) on newly hired CMA C.<br><br>For all residents, Administrator/LN A failed to obtain evidence of supporting documentation for criminal background checks of facility staff, pursuant to K.S.A. 39-970 and amendments thereto. | S5258 | | |