STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089089	A. BUILDING: _____ B. WING _____	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE OF ROSSVILLE	590 INDUSTRIAL TRAFFIC WAY ROSSVILLE, KS 66533

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S 000	INITIAL COMMENTS The following represent the findings of a resurvey for the above named Home Plus facility conducted on 01/02/24 and 01/03/24.	S 000		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c)(1) The facility reported a census of seven residents with three included in the sample. Based on observation, interview, and record review the operator failed to ensure a resident's "Functional Capacity Screen" (FCS) was completed at least once every 365 days for resident (R)103. Findings included: - Record review for resident (R)103 revealed an admission date of 08/26/22. The Admission FCS was completed on 08/26/22.	S5085		

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

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S5085	Continued From page 1 The Annual FCS was completed on 09/12/23, seventeen days past due. On 01/03/24 at 11:07 AM Administrative Staff A acknowledged R103's FCS was not revised within 365 days of the previous FCS. The operator failed to ensure designated staff revised the FCS at least once every 365 days.	S5085		
S5095 SS=D	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(d) The facility reported a census of seven residents with three included in the sample. Based on observation, interview, and record review the operator failed to ensure a resident's "Functional Capacity Screen" (FCS) accurately reflected the resident's status by the failure to document the use of a wheelchair. Findings included: - Record review for resident (R)103 revealed an admission date of 08/26/22.	S5095		

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S5095	Continued From page 2 The 08/26/22 Admission FCS identified R103 was independent with transfers and ambulation and did not require the use of an assistive device. The 09/12/23 FCS identified R103 was independent with transfers and ambulation and did not require the use of an assistive device. On 01/03/24 at 09:45 AM resident sat at the dining room table while sitting in a wheelchair. On 01/03/24 at 09:23 AM Certified Medication Aide (CMA) B stated R103 was for the most part independent with transfers and ambulation. CMA B stated R103 used a wheelchair when she had troubles with her knees. On 01/03/24 at 11:07 AM Administrative Staff A stated R103 occasionally used a wheelchair depending on how her arthritis was doing and acknowledged the FCS did not identify the use of a wheelchair. The operator failed to ensure R103's FCS accurately reflected her status by the failure to document the use of a wheelchair.	S5095		
S5116 SS=E	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100;	S5116		

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S5116	Continued From page 3 (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(1)(4) 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 review and revised as needed at least once every 365 days for resident (R)103 and failed to revise R102's NSA when she changed hospice providers. Findings included: - Record review for resident (R)103 revealed an admission date of 08/26/22. The Admission NSA was completed on 08/26/22. The Annual NSA was completed on 09/12/23 FCS seventeen days past due. On 01/03/24 at 11:07 AM Administrative Staff A acknowledged R103's NSA was not revised within 365 days of the previous NSA.	S5116		

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S5116	Continued From page 4 The operator failed to ensure designated staff revised the NSA at least once every 365 days. - Record review for R102 revealed an admission date of 11/16/23. The Admission NSA completed on 11/16/23 identified an outside hospice company provided services for R102. Review of the "Hospice Benefit Election Statement" revealed an admission date of 11/20/23 with the new hospice provider. On 01/03/24 at 11:02 AM Administrative Staff A stated there should have been an addendum completed when R102 changed hospice providers. The operator failed to ensure designated staff revised the NSA when R102 switched hospice providers.	S5116		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (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 home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and	S5215		

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S5215	Continued From page 5 (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 26-42-104(d)(3) 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 "Emergency Management Plan" (EMP) with employees and residents. Findings included: - On 01/02/24 the facility provided documentation for EMP reviews. No documentation was provided for resident reviews and lacked documentation that all staff completed a review of the EMP on a quarterly basis. On 01/02/24 at 01:25 PM Administrative Staff A stated most of the residents were not cognitively intact, so she did not review the EMP with the residents. On 01/03/24 at 11/20/24 AM Administrative Staff A stated she reviewed the EMP monthly with staff present during the monthly fire drill, and all staff reviewed the EMP on a yearly basis during an annual in-service. Administrative Staff A confirmed that the EMP was not reviewed with all	S5215		

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S5215	Continued From page 6 staff and all residents on a quarterly basis. The operator failed to ensure the performance of quarterly reviews of the emergency management plan with employees and staff.	S5215		
S5230 SS=E	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 the operator 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:	S5230		

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S5230	Continued From page 7 - Resident (R)102 was admitted to the facility on 11/16/23. Review of R102's medical records revealed a TB Screening Questionnaire was completed on 11/16/23 but a two-step "TB skin test" (TST) was not completed and there was no other documentation that indicated a two-step TST was completed within six months prior to R102's admission to the facility. On 01/03/24 at 11:02 AM Administrative Staff A stated R102 was a former resident at a different facility and believed that facility completed a two-step TST and if the results were obtained from the former facility, they would be in R102's medical chart. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of residency or employment ..." The operator 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 admitted residents. - R103 was admitted to the facility on 08/26/22. Review of 103's medical records revealed there was no documentation of an annual TB Screening Questionnaire completed for 2023. On 01/03/24 at 11:07 AM Administrative Staff A	S5230		

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S5230	Continued From page 8 stated there was not an annual TB symptom screening questionnaire completed for R103. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each resident ...shall have an annual TB symptom screen that includes the components of the Tuberculosis Symptom Screen Review Questionnaire." The operator 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.	S5230		
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 operator	S5313		

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S5313	Continued From page 9	S5313		

failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of "over the counter" (OTC) medications.

Findings included:

- Observation on 01/02/24 at 04:01 PM of the medication room revealed the following medications that were not labeled with the full name of resident:
Resident (R)101-
Two bottles of Ayr Saline Nasal Spray.

R102-
One bottle of Major Loperamide Hydrochloride Anti-Diarrheal

R104-
One bottle of Nature's Bounty Hair, Skin and Nails

R105-
One bottle of Mason Natural Saw Palmetto 500 milligrams (mg.).
One bottle of Health A2Z Aspirin 325 mg.
One bottle of Mason Natural C 500 mg.
One bottle of Good Neighbor Pharmacy Stool Softener

On 01/02/24 at 04:30 PM Administrative Staff A stated OTC medications should be labeled with the full name of the resident on medication containers.

The undated "Sample Medications and Over the Counter Medications" policy documented, "A

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S5313	Continued From page 10 licensed nurse or pharmacist must place the resident's full name on the package and the medication container." The operator failed to ensure all over the counter medications were labeled with the resident's full name.	S5313		