

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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 represents the findings of a resurvey with attached complaints #186640, #179731, and #178857 at the above named assisted living conducted on 03/21/24 and 03/25/24.	S 000		
S3026 SS=D	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(A) The facility reported a census of 40 residents with three residents included in the sample and one closed record review. Based on observation, interview, and record review the operator failed to protect one resident from abuse when a staff member held her hand over Resident (R) 1's mouth and nose to force her to swallow her medications when R1 tried to spit them out. Findings included: - Record review for R1 revealed an admission date of 10/18/22 with a diagnosis of dementia.	S3026		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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
S3026	Continued From page 1 The 10/06/22 (most recent) "Functional Capacity Screen" (FCS) identified R1 required physical assistance with bathing and dressing; was unable to perform management of medications and treatments; had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties; and was marked for impaired vision, impaired decision-making, and wandering. The 01/04/24 "Negotiated Service Agreement" (NSA) identified facility staff would provide R1 physical assistance with bathing, dressing, and toileting; assistance with management of medications; monitoring of vital signs for management of treatments; reminders to attend activities for cognitive difficulties, she was independent with vision aids for impaired vision; had a Durable Power of Attorney (DPOA) for impaired decision-making and facility staff provided redirection when wandering to prevent elopement. The 10/05/23 "Progress Note" by Certified Medication Aide (CMA) H documented R1 got mad during medication administration and tried to spit out her medications. The 03/20/24 "Progress Note" by Administrative Nurse B documented a Certified Nurse Aide (CNA) had reported a CMA used "inappropriate means" to get R1 to take her evening medications which violated her resident rights. The resident was provided frequent checks with no adverse outcomes noted after the incident. The 03/16/24 "Witness Statement" by CNA I	S3026		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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
S3026	Continued From page 2 documented CMA C crushed R1's medications and mixed them with chocolate syrup. R1 did not want to swallow the medications so CMA C plugged R1's nose shut. R1 could not breathe and tried to hit CMA C. After the incident, R1 vomited on the floor. The facility's 03/19/24 report to the department documented on 03/16/24 between 05:30 and 06:00 PM CNA I observed CMA C put her hand over R1's mouth to make her swallow her medications. R1 was assessed at 06:30 PM by Administrative Nurse B with no injury noted. R1 was reassessed on 03/17/24 by the hospice nurse with no injury noted. CMA C was suspended pending investigation. Observation on 03/25/24 at 01:42 PM revealed R1 laid in bed sleeping with the hospice nurse present. No facial bruising was observed. On 03/21/24 at 09:52 AM CMA J stated if a resident refused to take medications she would notify the nurse, back off, and try again later. She never forced a resident to take medications and had never witnessed other staff forcing residents to take medications. On 03/21/24 at 10:28 AM Licensed Hospice Nurse K stated she assessed R1 after the incident. R1 seemed to not remember the incident, did not seem traumatized or fearful of staff. R1 was calm and at her baseline. There were also no physical injuries. Licensed Hospice Nurse K had no other concerns about resident care at the facility. On 03/21/24 at 11:32 AM R1's unidentified family	S3026		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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
S3026	Continued From page 3 member stated she was told a CMA held her mother's nose and mouth shut to make her swallow her medications. When her mother walked back to her room she vomited. The CMA had been terminated. Her mother frequently refused to take her medications. She had no other concerns regarding care provided to her mother by the facility. On 03/21/24 at 12:01 PM during a phone interview, CNA I stated CMA C used her thumb and pointer finger to pinch R1's nose shut. R1 tried to hit CMA C with a fist. She immediately got up took about 10 steps and vomited. CNA I stated she had been provided training on reporting any witnessed abuse. On 03/21/24 at approximately 01:47 PM Administrative Staff A stated CMA C was terminated and no longer allowed to enter the facility. On 03/25/24 at 05:37 PM an Abuse, Neglect, and Exploitation policy was requested by email which the facility failed to provide. The operator failed to protect R1 from abuse when CMA C held her hand over R1's mouth and nose to force her to swallow her medications when R1 tried to spit them out.	S3026		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual 's admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall	S3080		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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
S3080	Continued From page 4 conduct a screening to determine the individual 's functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a) The facility reported a census of 40 residents with three residents included in the sample and one closed record review. Based on interview and record review the operator failed to ensure evidence of documentation a "Functional Capacity Screen" (FCS) was conducted for Resident (R) 4 on or before admission to the facility. Findings included: - Record review for R4 revealed an admission date of 03/16/23 with diagnoses of dementia and type two diabetes mellitus. The 03/24/24 "FCS" identified R4 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility; was unable to perform management of medications and treatments, was occasionally incontinent of bladder; he had short-term memory,	S3080		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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
S3080	Continued From page 5 memory/recall, and decision-making cognitive difficulties; and he was marked for falls and impaired decision-making. The 01/04/24 "Negotiated Service Agreement" (NSA) for R4 identified facility staff would provide physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and bladder incontinence, assistance for management of medications, report to the nurse changes in gait, ability to balance, and change in level of consciousness to prevent injury from falls. The "NSA" failed to describe services provided for management of treatments and cognitive difficulties. R4's record lacked evidence of documentation an "FCS" was conducted on or before admission. On 03/25/24 at 03:15 PM Administrative Staff A confirmed R4's record lacked evidence of documentation an "FCS" was conducted on or before admission. On 03/25/24 at 05:37 PM an "FCS" policy was requested by email which the facility failed to provide. The operator failed to ensure evidence of documentation an "FCS" was conducted for R4 on or before admission to the facility.	S3080		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following	S3081		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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
S3081	Continued From page 6 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 26-41-201(c)(1) The facility reported a census of 40 residents with three residents included in the sample and one closed record review. Based on interview and record review the operator failed to ensure designated staff completed a "Functional Capacity Screen" (FCS) for Resident (R) 1 every 365 days. Findings included: - Record review for R1 revealed an admission date of 10/18/22 with a diagnosis of dementia. The 10/06/22 (most recent) "FCS" identified R1 required physical assistance with bathing and dressing; was unable to perform management of medications and treatments; had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties; and was marked for impaired vision, impaired decision-making, and wandering. The 01/04/24 "Negotiated Service Agreement" (NSA) identified facility staff would provide R1 physical assistance with bathing, dressing, and	S3081		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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
S3081	Continued From page 7 toileting; assistance with management of medications; monitoring of vital signs for management of treatments; reminders to attend activities for cognitive difficulties, she was independent with vision aids for impaired vision; had a Durable Power of Attorney (DPOA) for impaired decision-making and facility staff provided redirection when wandering to prevent elopement. R1's record lacked evidence of an "FCS" since the 10/06/22 "FCS" which was 522 days from date of the resurvey and 157 days overdue. On 03/21/24 at 01:47 PM Administrative Nurse B confirmed R's1 most recent "FCS" was on 10/06/22. On 03/25/24 at 05:37 PM an "FCS" policy was requested by email which the facility failed to provide. The operator failed to ensure designated staff completed an "FCS" for R1 every 365 days.	S3081		
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	S3085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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 8 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) The facility reported a census of 40 residents with three residents included in the sample and one closed record review. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreements" (NSA) for Residents (R) 1, R2, R3, and R4 described the services they received based on their "Functional Capacity Screens" (FCS) and service needs. Findings included: - Record review for R1 revealed an admission date of 10/18/22 with a diagnosis of dementia. The 10/06/22 (most recent) "FCS" identified R1 was unable to perform management of medications. The 01/04/24 "NSA" identified facility staff would provide R1 assistance with management of medications. The "NSA" failed to describe services R1 received for exhibited behaviors of resisting medication administration.	S3085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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 9 The 10/05/23 "Progress Note" by Certified Medication Aide (CMA) H documented R1 got mad during medication administration and tried to spit out her medications. On 03/21/24 at 11:32 AM R1's unidentified family member stated R1 frequently refused to take her medications. - Record review for R2 revealed an admission date of 01/22/21 with a diagnosis of dementia. The 01/04/24 "FCS" identified R2 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties and was marked for impaired vision and impaired hearing. The 01/04/24 "NSA" failed to describe services R2 received for cognitive difficulties, impaired vision, and impaired hearing. - Record review for R3 revealed an admission date of 03/19/24 with a diagnosis of cerebral infarction. The 03/07/24 "FCS" identified R3 required supervision with bathing and dressing and was occasionally incontinent of bladder. The "FCS" had a handwritten note which read "resistive to hands on care, inappropriate language verbalized to staff at times." The 01/04/24 "NSA" identified facility staff would provide R3 reminders and assistance to ensure good hygiene with bathing and reminders and assistance to ensure he was dressed appropriately. The "NSA" failed to describe services R3 received for resisting care and	S3085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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 10 inappropriate behavior. The 03/24/24 "Progress Note" documented R3 refused to take medications or let staff assist him to get out of bed when his blanket was wet with urine. On 03/25/24 at approximately 02:16 PM Administrative Nurse B stated R3 resisted care and exhibited inappropriate behavior by asking staff to sit on his lap. - Record review for R4 revealed an admission date of 03/16/23 with diagnoses of dementia and type two diabetes mellitus. The 03/24/24 "FCS" identified R4 was unable to perform management of treatments and he had short-term memory, memory/recall, and decision-making cognitive difficulties. The 01/04/24 "NSA" failed to describe services provided R4 for management of treatments and cognitive difficulties. On 03/25/24 at approximately 02:16 Administrative Nurse B confirmed R1, R2, R3, and R4's "NSA's" failed to describe the services provided based on their "FCS's" and service needs. On 03/25/24 at 05:37 PM an "NSA" policy was requested by email which the facility failed to provide. The operator failed to ensure the "NSA's" for R1, R2, R3, and R4 described the services they received based on their "FCS" and service needs.	S3085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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
S3090 SS=D	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(c) The facility reported a census of 40 residents with three residents included in the sample and one closed record review. Based on interview and record review the operator failed to ensure the development of an initial "Negotiated Service Agreement" (NSA) at admission for Residents (R) 3 and R4. Findings included: - Record review for R3 revealed an admission date of 03/19/24 with a diagnosis of cerebral infarction. The 03/07/24 "Functional Capacity Screen" (FCS) identified R3 was unable to perform management of medications and treatments and was occasionally incontinent of bladder. The 03/25/24 "NSA" identified facility staff would provide assistance with management of medications and monitoring of vital signs for management of treatments. Bladder incontinence was not addressed.	S3090		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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
S3090	Continued From page 12 R3's record lacked evidence of documentation an "NSA" was completed at admission on 03/19/24. On 03/25/24 at approximately 02:16 PM Administrative Nurse B confirmed R3 admitted on 03/19/24 and lived in the facility six days before his "NSA" was developed on 03/25/24. - Record review for R4 revealed an admission date of 03/16/23 with diagnoses of dementia and type two diabetes mellitus. The 03/24/24 "FCS" identified R4 was unable to perform management of treatments and he had short-term memory, memory/recall, and decision-making cognitive difficulties. The 01/04/24 "NSA" failed to describe services provided R4 for management of treatments and cognitive difficulties. On 03/25/24 at approximately 02:16 PM an admission "NSA" for R4 was requested which the facility failed to provide. On 03/25/24 at 03:15 PM Administrative Staff A confirmed R4's lacked evidence of documentation an "NSA" was developed at admission. On 03/25/24 at 05:37 PM an "NSA" policy was requested by email which the facility failed to provide. The operator failed to ensure the development of an initial "NSA" at admission for R3 and R4.	S3090		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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
S3210	Continued From page 13	S3210		
S3210 SS=F	26-41-205 (e) (f) Medication Verbal Orders and Standing Orders (e) Medication orders. Only a licensed nurse or a licensed pharmacist may receive verbal orders for medication from a medical care provider. The licensed nurse shall ensure that all verbal orders are signed by the medical care provider within seven working days of receipt of the verbal order. (f) Standing orders. Only a licensed nurse shall make the decision for implementation of standing orders for specified medications and treatments formulated and signed by the resident ' s medical care provider. Standing orders of medications shall not include orders for the administration of schedule II medications or psychopharmacological medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(e) The facility reported a census of 40 residents with three included in the sample and one closed record review. Based on interview and record review the operator failed to ensure a licensed nurse ensured all verbal orders were signed by the medical care provider within seven working days of receipt of the verbal order. Findings included: - Record review for R1 revealed an admission date of 10/18/22 with a diagnosis of dementia.	S3210		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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
S3210	Continued From page 14 The 10/06/22 (most recent) "FCS" identified R1 was unable to perform management of medications. The 01/04/24 "NSA" identified facility staff would provide R1 assistance with management of medications. Review of verbal orders for R1 revealed three orders lacked provider's signatures from 01/11/24 to 03/21/24. - Record review for R2 revealed an admission date of 01/22/21 with a diagnosis of dementia. The 01/04/24 "FCS" identified R2 was unable to perform management of medications. The 01/04/24 "NSA" identified facility staff would provide R1 assistance with management of medications. Review of verbal orders for R2 revealed four orders lacked provider's signatures from 01/11/24 to 03/21/24. - Record review for R4 revealed an admission date of 03/16/23 with diagnoses of dementia and type two diabetes mellitus. The 03/24/24 "FCS" identified R4 was unable to perform management of medications and he had short-term memory, memory/recall, and decision-making cognitive difficulties. The 01/04/24 "NSA" identified facility staff would provide assistance with management of medications.	S3210		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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
S3210	Continued From page 15 Review of verbal orders for R3 revealed six orders lacked provider's signatures from 01/18/24 to 03/21/24. On 03/25/24 at approximately 02:16 PM Administrative Nurse B confirmed the provider's verbal orders lacked evidence of documentation they were signed within seven working days for all residents at the facility. The operator failed to ensure a licensed nurse ensured all verbal orders were signed by the medical care provider within seven working days of receipt of the verbal order.	S3210		
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; 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.	S3280		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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 16 This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 40 residents. Based on interview and record review the operator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan were conducted with staff during the first and third quarters of 2023. Findings included: - Review of the facility's emergency plan records revealed lack of evidence of documentation quarterly reviews of the emergency management plan were conducted with staff during the first and third quarters of 2023. On 03/25/24 at approximately 03:23 PM Administrative Staff A confirmed the facility's record lacked documentation reviews of the emergency management plan were completed the first and third quarters of 2023 with staff. The August 2021 facility's "Emergency Procedures" policy documented the state and local regulatory guidelines should be incorporated into the policy and Executive Directors will need to add emergency preparedness policies based on the state and local needs. The operator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan were conducted	S3280		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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 17 with staff during the first and third quarters of 2023.	S3280		
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) The facility reported a census of 40 residents. The facility had a main kitchen where food was stored, prepared, and served and a satellite kitchen in the memory care where food was stored. Based on observation and interview the operator failed to ensure food items were stored under safe conditions. Findings included: - Observation on 03/21/24 at 09:45 AM revealed a satellite kitchen in the memory care unit had a refrigerator that contained food items for the residents. The following food items were inside the refrigerator: One serving size container of chocolate pudding that was half full, had no cover, and was not marked with the open date. One serving size container of Ensure with a	S3299		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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 18 straw sticking out, had no lid, and was not marked with the open date. One serving size clear plastic bowl with an orange substance had no cover or date mark. One 60-ounce (oz) container of cranberry juice cocktail that was one third full and was not marked with the open date. One gallon size container of orange juice that was one-fourth full and was not marked with the open date. On 03/21/24 at approximately 09:45 AM Certified Nurse Aide (CNA) E confirmed several food items for residents in the memory care unit refrigerator were not covered and/or marked with an open date. The Kansas Department of Agriculture's "Focus on Food Safety" booklet documented cold foods should be covered during storage. Foods must be date marked after the original container was opened and held under refrigeration. - Observation on 03/21/24 at 09:58 AM of the main kitchen revealed a plastic zipper storage bag with what appeared to be a white powder substance inside sat on a shelf. Next to the bag was an open container of clear liquid with a cleaning rag floating in it. Dietary staff F and G stated the bag contained flour that was to be used for baking later in the day and the clear liquid was sanitizer and confirmed they sat next to each other on the shelf. The Kansas Department of Agriculture's "Focus on Food Safety" booklet documented sanitizers	S3299		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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 19 can be poisonous or toxic and must be stored separately from foods. On 03/25/24 at 05:37 PM a food storage policy was requested by email which the facility failed to provide. The operator failed to ensure foods were stored under safe conditions.	S3299		
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 40 residents with three residents included in the sample and one closed record review. Based on interview and record review the operator failed to ensure	S3310		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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 20 the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for two residents and one staff. Findings included: - Record review for Resident (R) 1 revealed an admission date of 10/18/22 with a diagnosis of dementia. The 10/31/22 (13 days after admission) first step of the two-step TB skin test for R1 was negative. R1's record lacked evidence of documentation an initial TB symptom screen and a TB skin test was administered within seven days of residency, and a second step of the two-step TB skin test was administered. - Record review for R4 revealed an admission date of 03/16/23 with a move in date of 04/05/23. The 11/17/23 (226 days after moving in) first step of the two-step TB skin test for R4 was negative. The 12/01/23 second step TB skin test was also negative. R4's record lacked evidence of documentation an initial TB symptom screen and a TB skin test was administered within seven days of residency. On 03/25/24 at approximately 02:16 PM Administrative Nurse B confirmed R1's second TB skin test was not administered and R4's TB symptom screen and TB skin test was not administered within seven days of admission.	S3310		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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 21 - Review of Certified Nurse Aide (CNA) L's employee record revealed a hire date of 04/05/23 and lacked evidence of documentation of TB testing. On 03/25/24 at approximately 03:23 PM Administrative Staff A confirmed CNA L's record lacked evidence of documentation of TB testing. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee and each new resident shall receive a two-step TB skin test and symptom screen questionnaire within seven days of employment or admission. On 03/25/24 at 05:37 PM an "TB" policy was requested by email which the facility failed to provide. 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.	S3310		