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	B006006	A. BUILDING: _____ B. WING _____	03/28/2024

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CREDO MEMORY CARE OF FTSCOTT	822 S HORTON STREET FORT SCOTT, KS 66701

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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints #186638, #186619, #186364, #186329, #186347, and #184068 at the above named home plus conducted on 03/27/24 and 03/28/24.	S 000		
S5026 SS=K	26-42-101 (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 26-42-101(f)(1)(A)(B) The facility reported a census of 12 residents with six residents included in the sample. Based on observation, interview, and record review the operator failed to protect three cognitively impaired residents from abuse and neglect by the failure to ensure all direct care staff treated them with dignity, respect, and an appropriate response towards their diagnoses and associated behaviors of dementia (and history of trauma for Resident (R) 2). The operator failed to keep residents safe during transfers by ensuring all direct care staff provided safe transfer	S5026		

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

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practices to minimize injury. The operator failed to ensure all direct care staff reported injuries to the nurse. The operator failed to ensure all nursing care was provided by, or under the guidance of, a licensed nurse. These failures resulted in Immediate Jeopardy when R2 suffered skin tears of unknown origin on 03/15/24 and bruises and a bump on her head of unknown origin on 03/17/24; R3 suffered a bruise on her upper arm on 03/17/24; and R1 was threatened to be drowned on 03/17/24. The facility reported all 12 residents were cognitively impaired.

Findings included:

- Record review for R2 revealed an admission date of 01/23/24 with a diagnosis of Alzheimer's Disease.

The 01/23/24 "Functional Capacity Screen" (FCS) identified R2 required physical assistance with bathing and dressing; was unable to perform management of medications and treatments; was occasionally incontinent of bladder; had short-term and long-term memory, memory/recall, and impaired decision-making cognitive difficulties; was sometimes understandable and sometimes understood others during communication; and was marked for falls, impaired decision-making, wandering, and inappropriate behavior.

The 01/24/24 "Negotiated Service Agreement" (NSA) identified facility staff provided R2 physical assistance with bathing, dressing, toileting, and changing incontinence products for incontinence of bladder; management of

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medications and treatments; redirection and cueing for cognitive difficulties; clear explanation of all care activities prior to and as they occurred, and step-by-step personalized best practices using calm voice for communication; clutter free environment and bed in low position at night to prevent injury from falls; monitoring and reporting to nurse for wandering and behaviors; and R2 had a durable power of attorney (DPOA) for impaired decision-making.

Review of "Orders" by R2's primary care provider (PCP) revealed she did not take any blood thinning medication or any other medication that might cause increased bruising side effects.

The back of the 03/15/24-03/17/24 "Incident Report" form by Certified Nurse Aide (CNA) D contained handwritten notes which read as follows:

03/15/24 - while R2 was in the bathroom CNA D stepped away to get a trash bag and first aid supplies. When he returned R2 had transferred herself from the toilet to her bed and had blood on her incontinence brief. CNA D "dressed" three wounds as follows:
One on unidentified heel caused by friction from rocking herself in a chair.
One on her right ring finger from and unknown source.
One skin tear on her left forearm.

03/17/24 - R2 was last seen sitting in her usual chair. After CNA D returned from assisting another resident, R2 sat in an opposite chair. CNA D assisted her up and noticed "a deformity" on her head. He immediately sat R2 down and

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notified the Certified Medication Aide E. Vital signs were taken, and an ice pack was placed until hospice arrived to check on the resident. A note at the bottom of the report read CNA D noticed bruises on R2's hand when he arrived to work on Friday (03/22/24) which he had no knowledge of.

The 03/17/24 "Incident Report" form filled out by CMA E reported at 04:10 PM R2 was found sitting across from her original seat after CNA D returned from assisting another resident. CNA D noticed a "bump" on the side of her head with instant bruising. Vital signs were within normal ranges. R2's representative was notified at 04:27 PM. A question in red letters which read "Was the on-call nurse notified?" with check boxes to mark yes or no were left blank. The "Narrative Section (Trends - Patterns / Steps Taken to Prevent Recurrence: Must be completed thoroughly by nurse or Operator" was also left blank.

The 03/17/24 "Incident Note" by Administrative Nurse C documented a CMA reported R2 was last seen in the common area sitting in a recliner. Staff left the area and upon returning, saw the resident sitting in a different recliner. The CNA on duty noticed R2 had a bruise on the left side of her forehead and left scalp above her ear. The CMA also reported a new bruise on R2's left hand and bandages to her left elbow and left forearm. No reports of skin issues were made to Administrative Nurse C prior to CMA's report.

The 03/17/24 at 05:50 PM "Coordination Note" in hospice records by Licensed Nurse N documented the facility reported R2 had an

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unwitnessed fall. R2 sat in a recliner upon Licensed Nurse N's arrival to the facility. A small lump on the left side of her head was noted with bruising. Medication for restlessness was administered and fall precautions were reviewed with CMA E.

The undated skin assessment by Administrative Nurse C documented the following for R2:
4.0 by 1.1 centimeter (cm) purple bruise on left forehead
2.5 by 0.25 cm bruise on left side of head
0.5 by 0.5 cm skin tear on left elbow
4.0 by 3.0 cm bruise on left forearm
1.0 by 1.4 cm skin tear on left wrist
9.0 by 10.0 cm purple bruise on left hand
5.0 by 4.0 cm yellow bruise to chest (from sternal rub)
4.0 by 8.0 cm light purple bruise on back of right arm
2.5 by 1.2 cm circular bruise on right hand
Scattered bruising on right forearm

The 03/18/24 notarized "Witness Statement" by CNA F reported on 03/16/24 or 03/17/24 CNA D pushed R2 to make her walk faster to the bathroom. CNA F heard R2 call out. She had a bruise on her left hand and a "knot" on the left side of her head. After supper CNA D "shoved" R2 down in a chair.

The 03/18/24 notarized "Witness Statement" by CNA G reported CNA D transferred residents by grabbing the top of their hands. She noticed toward the end of her shift some residents had bruises.

The 03/19/24 notarized "Witness Statement" by

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CNA H reported CNA D grabbed R2 aggressively by the arm and "dragged" her to a chair in the living room.

Observation on 03/27/24 at 11:28 AM revealed Administrative Nurse B conducted a head-to-toe skin assessment for R2. Multiple dark yellowish bruises were observed on the left side of her forehead, left side of face in front of her ear, behind her left ear and on the left side of her neck. A light yellowish circular bruise was in the center of her chest over her sternum.

On 03/27/24 at approximately 01:40 PM CMA J stated she had worked at the facility for 3 years and had never noticed suspicious bruising on residents before CNA D worked there. She had witnessed he had a rude tone while interacting with the residents but had never witnessed him physically abuse them.

On 03/27/24 at approximately 01:55 PM CMA K stated he reported to Administrative Staff I on 03/15/24 some residents had bruises caused by CNA D. He had witnessed CNA D was rough with the residents. He "dragged" residents back to their rooms by wrapping his arm under their armpits while the resident tried to grab the side rails in the hallway and screamed. He stated Administrative Staff I did not do anything about his report.

On 03/28/24 at 09:05 AM during phone interview CNA D stated the following:

He worked at the facility since January but did not work there anymore. His co-workers had accused him of being too rough or aggressive

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with the residents, which surprised him. He understood why he was being investigated for abusiveness towards R2 because he did not handle it properly. He wished he had handled it differently. He forgot to write a report on 03/15/24 noting R2 had skin tears because he got sidetracked that day.

CNA D stated he assisted R2 to the toilet on 03/15/24 and left to answer a call light. When he returned, R2 had moved herself off the toilet and sat in a chair in her room with her pants down around her ankles. R2 had a cut on her left forearm and right ring finger. R2 had a sore on her right heel from a previous injury caused by rubbing her heel wrong. He assumed she fell and caused the skin tears. CNA D got the first aid kit and dressed R2's wounds.

CNA D stated R2 sat in a recliner in the common area closest to the fireplace on 03/17/24. He went to check and change another resident and when he returned R2 had moved and sat in a recliner closest to the window. Another resident, R3, tried to help R2 up. CNA D assisted R2 to transfer from the recliner because another resident adamantly liked to sit in that chair. During the transfer he noticed a bump on R2's head and alerted CNA F. CMA E was then contacted.

CNA D stated he never forcefully walked a resident too fast so they stumbled or could not keep up.

CNA D stated he did not witness any current staff treating residents abusively. He was not sure if R2 had any unwitnessed falls because there

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were a lot of things that happened, and reports were not written.

CNA D stated the normal process for reporting injuries was to inform the CMA to see what they thought and then he tried to contact the nurse. If staff were unable to reach the nurse, a report was made to Administrative Staff I. He reported R2 had a heel wound (before the other skin tears occurred) to Administrative Nurse C on a paper report, which should have been in Administrative Nurse C's office. He stated he slid the report under her office door. CNA D then said "No, I take that back. The heel wound was reported by CNA G by calling Administrative Nurse C who was also her mom.

CNA D stated a nurse did not delegate him to provide first aid care for resident skin wounds and he was not provided skills training on how to care for skin wounds.

On 03/28/24 at approximately 11:50 AM CNA H stated the following:

She worked at the facility about five weeks and worked with CNA D. She never had any concerns regarding CNA D's treatment of residents while she worked with him on night shift. But on 03/17/24 she worked a day shift with CNA D for the first time. She witnessed as he approached R2 from behind while R2 sat in a chair at a table in the dining area and grabbed her upper arm. Without saying a word, CNA D pulled R2 out of the chair and led her to a recliner in the common area while still holding onto to her upper arm. R2's feet shuffled, and she was able to keep up but she hung behind CNA D and leaned

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backwards. As they approached the recliner, R2 still leaned backwards and "flopped" into the recliner with CNA D still holding onto her upper arm. It was typical for R2 to stiffen and lean backwards. CNA D did not assist R2 to ease into the recliner. CNA D then grabbed the footrest raised it rapidly and walked off. CNA D did not speak to R2 to explain what he was doing during the entire interaction. R2 was a child victim of sexual assault and had a lot of traumas. She had a general fear of men, which made it hard for male staff to work with her. R2 was not able to express pain but had a noticeable bruise on her upper arm that evening.

CNA H stated that later on 03/17/24 as CNA D gave her report at the end of his shift, he pointed out a "goose egg" on R2's head and said she had a fall. CNA H asked how the fall happened and CNA D reported he did not know, but she had fallen between the TV and a recliner in the common area and R3 helped R2 get back up. CNA H stated R3 was very unsteady on her feet, could not walk on her own, and could not have helped R2 to get up. R2 could transfer herself from one recliner to another but required the assistance of two staff to get up off the floor.

CNA H stated later that evening on 03/17/24 she assisted R2 to get ready for bed. She noticed a large bruise in the center of her chest that went down towards her left nipple and a thumb sized bruise over her rib cage under her right breast. There were a lot of other bruises as well. R2 did not typically run or fall into things. One fall CNA H recalled happened when R2 tripped over a cord in another resident's room.

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S5026	Continued From page 9 CNA H stated when CNA D began working day shifts the bruises began showing up. CNA H stated she notified CMA E about the bruises on 03/17/24. CMA E reported the bruises to Administrative Nurse C who instructed CMA E to fill out a skin report with all the bruises that could be seen to be able to track any new bruises. CNA H stated CNA D did not work anymore and there were no new bruises. CNA H stated it was not in her scope of practice to administer first aid for skin tears. It was normal in the facility that all skin tears or bleeding were reported to the CMA. On 03/28/24 at 12:56 PM Administrative Nurse B stated she expected the nurse to be notified if direct care staff noticed any bruises, skin tears, or bleeding on residents. The nurse would give instructions for first aide to direct care staff or administer treatment herself. The operator failed to protect R2 from abuse and neglect by the failure to ensure all direct care staff treated her with dignity and respect with appropriate response towards her with a diagnosis of dementia and past history of trauma; provided clear explanation of all care activities prior to and as they occurred per her "NSA;" all direct care staff used safe transfer practices to minimize injury; all direct care staff reported injuries to the nurse; and all nursing care was provided by, or under the guidance of a licensed nurse. - Record review for R3 revealed an admission date 12/24/23 with a diagnosis of dementia.	S5026		

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S5026	Continued From page 10 The 12/14/23 "FCS" identified R3 required physical assistance with bathing, dressing, walking/mobility; was unable to perform management of medications and treatments; was occasionally incontinent of bladder; had short-term, memory/recall, and decision-making cognitive difficulties; and was marked for falls and impaired decision-making. The 12/14/23 "NSA" identified facility staff would provide R3 assistance with bathing, dressing, toileting, changing incontinence products for incontinence of bladder, and walking/mobility using a wheelchair or roller walker; management of medications and treatments; safety checks every 30 minutes and redirection as needed for cognitive difficulties; she liked to lay on the floor at times, ensure clutter-free environment, and keep assistive devices available and in good repair to prevent injury from falls; and she had a DPOA for impaired decision-making. The 03/19/24 "Intake Information" report to the department reported CNA D reportedly shoved R3 into a chair and yelled at her not to move out of the chair. Later CNA D walked with R3 shoving her, making her run and stumble. The 03/18/24 notarized "Witness Statement" by CNA F reported CNA D interacted with R3 roughly on 03/17/24. CNA D grabbed R3's arm, shoved her into a chair, and told her not to get up. The 03/18/24 notarized "Witness Statement" by CNA G reported CNA D transferred residents by grabbing the top of their hands. She noticed	S5026		

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toward the end of her shift some residents had bruises.

Observation on 03/27/24 at 11:19 AM revealed Administrative Nurse B conducted a head-to-toe skin assessment for R2 with no bruising observed.

On 03/28/24 at 09:05 AM during a phone interview CNA D stated he was always telling R3 to sit down. She was a fall risk and refused to use her walker. All the CNA's were constantly telling her to sit down. He knew family members thought he spoke too loudly. He was still in his "blue-collar, military" mode. He never yelled at residents, but occasionally called their name from across the room and said "Hey, _____, don't do that." He stated he never forcefully walked a resident too fast so they stumbled or could not keep up.

The operator failed to protect R3 from abuse and neglect by the failure to ensure all direct care staff treated her with dignity and respect, all direct care staff used safe transfer practices to minimize injury, and all direct care staff reported all injuries to the nurse.

- Record review for R1 revealed an admission date of 09/08/21 with a diagnosis of dementia.

The 08/03/23 "FCS" identified R1 required physical assistance with bathing, dressing, toileting, transfers, and walking/mobility; was unable to perform management of medications and treatments; was occasionally incontinent of bladder; had short-term memory, memory/recall, and decision-making cognitive difficulties; and

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she was marked for falls, impaired vision, and impaired decision-making.

The 12/19/23 "NSA" identified facility staff would provide R1 assistance with bathing, dressing, toileting every two hours and change incontinence briefs as needed for bladder incontinence; management of medications and treatments; safety checks every 30 minutes and redirection for cognitive difficulties; and safety checks every 30 minutes and assistance when trying to stand independently to prevent injury from falls; ensure her glasses were on and clean every morning for impaired vision; and she had a DPOA for impaired decision-making.

The 03/18/24 "Intake Information" report to the department reported CNA D told a resident he was going to drown her.

The 03/19/24 "Intake Information" report to the department reported CNA D told R1 he was going to drown her.

The 03/19/24 notarized "Witness Statement" by CNA G reported she noticed CNA D became agitated and verbally inappropriate throughout the week. For example, CNA D told a resident he was going to drown her.

The 03/19/24 notarized "Witness Statement" by CMA E reported on 03/17/24 R1 became upset yelling and cussing. CNA D said he would drown her.

The 03/21/24 "Witness "Statement" by CMA E reported she and CNA G and CMA M went to Administrative Staff I on 03/17/24 to report a

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CREDO MEMORY CARE OF FTSCOTT	822 S HORTON STREET FORT SCOTT, KS 66701

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verbal threat made to R1 in the memory care unit. Administrative Staff I did not seem concerned and after a brief discussion CMA E, CNA G, and CMA M exited Administrative Staff I's office.

Observation on 03/27/24 revealed R1 propelled herself in a wheelchair down the hallway of the facility. No bruises were visible on face, forearms, or hands.

On 03/28/24 at approximately 09:05 AM CNA D stated he was still in his "blue-collar, military" mode and would sometimes say things "off the cuff" to co-workers jokingly, but never directly to residents. He never yelled at residents or threatened them in a serious way. On a stressful day he may make a "broad-spectrum" comment that "we're going to box today." It was never meant as a threat. He never threatened to drown a resident and did not know why someone would accuse him of saying that.

The operator failed to protect R1 from abuse and neglect by the failure to ensure all direct care staff treated her with dignity and respect with appropriate response towards her with a diagnosis and associated behaviors of dementia.

The 03/27/24 "Resident Roster" provided by the facility revealed all 12 residents were marked for impaired cognition.

The 03/18/24 note included in the facility's "Investigation" to the department documented the following interventions:

1) Administrative Staff A and Administrative

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S5026	Continued From page 14 Nurse C conducted an in-service on 03/19/24 with staff on reporting abuse, neglect, and exploitation. Staff were also visually shown how to properly use a gait belt for transfers. 2) CNA D self-terminated after he was asked to write a witness statement. 3) Administrative Staff I was terminated due to failure to report allegations of abuse, failure to begin an investigation immediately after being informed of alleged abuse, and failure to take immediate measures to ensure the safety of the residents. The 03/19/24 "Prevention of Abuse, Neglect, and Exploitation and Gait Belt Training" in-service documented 19 staff signatures which indicated attendance. The 03/28/24 notarized "Witness Statement" by Administrative Staff A documented the following: On 03/18/24 at approximately 10:45 AM Administrative Nurse C informed Administrative Staff A that on 03/17/24 at approximately 06:30 PM several staff brought concerns regarding care provided to the residents by CNA D. Concerned staff reported to Administrative Nurse C they informed Administrative Staff I of their concerns on 03/17/24 at approximately 02:00 PM. On 03/18/24 at approximately 05:53 PM CNA D called Administrative Staff A to report he self-terminated.	S5026		

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S5026	Continued From page 15 On 03/19/24 at approximately 10:45 AM Administrative Staff I was terminated for not following the facility's policies and procedures to report abuse allegations. On 03/19/24 at 02:00 PM an emergency meeting was held for all employees to discuss abuse, neglect, and exploitation; and when, how, and to whom to report abuse. Gait belt training was also demonstrated for direct care staff. Record review of CNA D's employee record revealed a hire date of 01/01/24. The CNA registry was contacted on 12/23/23 to provide evidence of certification. A Kansas Bureau of Investigation background check was conducted which indicated no previous findings of having abused, neglected, or exploited a resident in an adult care home. Review of CNA D's timecard revealed he began working at the facility on 01/01/24. From 01/01/24 to 01/30/24 CNA D worked 22 shifts during the night. From 02/01/24 to 02/27/24 CNA D worked 18 shifts during the night and one evening shift on 02/01/24. From 03/01/24 to 03/08/24 CNA D worked five shifts during the night. From 03/11/24 to 03/17/24 CNA D worked five shifts during the day. He clocked out for the last time on 03/17/24 at 06:09 PM. Observation on 03/27/24 at 09:31 AM revealed seven residents sat at tables in the dining area of the facility. They appeared calm and relaxed and did not appear fearful or withdrawn from the three staff present who were providing care. One CMA assisted a resident to transfer from a chair in the dining area to sit on a sofa in the common	S5026		

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area using a gait belt without difficulty.

On 03/27/24 at approximately 01:40 PM CMA J stated she had been provided training regarding abuse, neglect, and exploitation and the use of gait belts during transfers during monthly in-service meetings, which was reviewed "about two weeks ago."

On 03/27/24 at 03:44 PM CNA O stated she began working at the facility a few days ago. She was provided training regarding abuse, neglect, and exploitation and when, how, and to whom to report. Since she began working, she had not noticed any unexplained injuries on residents.

On 03/28/24 at approximately 09:05 AM CNA D stated he was provided training regarding abuse, neglect, and exploitation, but did not remember when. He was never provided dementia training. Training regarding how to transfer residents was provided during CNA class last October but no transfer training was provided by the facility.

On 03/28/24 at approximately 11:50 AM CNA H stated all staff were required to attend an emergency, mandatory, in-service regarding abuse, neglect, and exploitation on 03/19/24 at 01:30 PM. She was not able to attend as she was working on the floor but was provided training by Administrative Staff A later. She was also shown how to use gait belts during transfers. She was not provided dementia training at the facility, just what she had learned in her CNA class.

The facility's revised 2022 "Reporting Requirement in cases of Abuse, Neglect, and

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Exploitation" policy documented the following:

The director of the facility would thoroughly investigate all cases of suspected abuse, neglect, and exploitation; notify the abuse hotline; report to local law enforcement; keep a written record of allegations; and take all necessary actions to keep the residents safe.

The director would be notified immediately of any issues from abuse, neglect, or exploitation could be alleged. After gathering the initial facts, the director should report the issue to the regional director of the corporation by phone and fax. Each allegation of abuse, neglect, or exploitation shall be reported to the Kansas Department for Aging and Disability Services withing 24 hours.

The director should begin an investigation of any allegations immediately upon being notified and take immediate measures to prevent further potential abuse, neglect, or exploitation while the investigation in is process.

The operator failed to protect three cognitively impaired residents from abuse and neglect by the failure to ensure all direct care staff treated them with dignity and respect with appropriate response towards their diagnoses and associated behaviors of dementia (and history of trauma for R2). The operator failed to keep residents safe during transfers by ensuring all direct care provided safe transfer practices to minimize injury. The operator failed to ensure all direct care staff reported injuries to the nurse. The operator failed to ensure all nursing care was provided by, or under the guidance of a licensed nurse. These failures resulted in

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S5026	Continued From page 18 Immediate Jeopardy when R2 suffered skin tears of unknown origin on 03/15/24 and bruises and a bump on her head of unknown origin on 03/17/24; R3 suffered a bruise on her upper arm on 03/17/24; and R1 was threatened to be drowned on 03/17/24. The Immediate Jeopardy was removed on 3/28/24 when the following actions were documented by the facility in the "Abatement Plan" and accepted by the department at 08:56 AM. 1) On 03/18/24 at approximately 10:30 AM Administrative Staff A was notified of alleged abuse. 2) On 03/18/24 at approximately 11:00 AM Administrative Staff A notified Senior Regional Director and Chief Operating Officer (COO) of alleged abuse. 3) On 03/18/24 an investigation began by gathering witness statements 4) On 03/18/24 at approximately 04:00 PM report of alleged abuse was made to the department. 5) On 03/18/24 at approximately 05:53 PM CNA D called Administrative Staff A and self-terminated 6) On 03/19/24 at approximately 10:45 AM Administrative Staff I was terminated for failure to report an abuse allegation 7) On 03/19/24 an emergency in-service meeting was conducted for all staff to discuss abuse, neglect, and exploitation and when, how, and to whom to report abuse. 8) On 03/19/24 an emergency in-service meeting was conducted for direct care staff to train on the use of gait belts for transferring	S5026		

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S5026	Continued From page 19 residents 9) Dementia training for all staff was scheduled for 04/04/24 at 02:00 PM	S5026		
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 (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 12 residents. Based on interview and record review the operator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan with staff and residents were completed. Findings included:	S5215		

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S5215	Continued From page 20 - Review of the facility's emergency plan records revealed a review of the emergency management plan was conducted for staff on 07/26/23. The record lacked evidence of documentation quarterly reviews were completed with staff during the first, second, and fourth quarter of 2023 and with residents for all quarters of 2023. On 03/28/24 at 11:14 AM Administrative Staff A confirmed the facility's record lacked documentation reviews of the emergency management plan were completed quarterly with staff and residents. The revised 2022 facility's "Emergency and Disaster Preparation In-Service" policy documented instructions at the top to review the contents and procedures in the Emergency Manual. The "Emergency Manual Employee Acknowledgment" provided a statement the contents of the Emergency Manual were read and understood with lines to sign and date the acknowledgment. No other policy was provided by the facility. The operator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan with staff and residents were completed.	S5215		
S5230 SS=F	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	S5230		

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S5230	Continued From page 21 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 12 residents with six residents included in the sample. 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 for one resident and one staff. Findings included: - Record review for Resident (R) 2 revealed an admission date of 01/23/24 with a diagnosis of dementia. The 01/23/24 first step of the two-step TB skin test for R2 was negative. R1's record lacked evidence of documentation the second step of the two-step TB skin test was administered.	S5230		

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S5230	Continued From page 22 On 04/01/24 at approximately 01:02 PM during findings meeting conducted remotely by phone Administrative Staff A confirmed R2's record lacked evidence of documentation the second step of the two-step TB skin test was administered. - Review of Administrative Nurse C's employee record revealed a hire date of 10/19/23 and lacked evidence of documentation of TB testing. On 03/28/24 at 12:44 PM Administrative Staff A confirmed Administrative Nurse C'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. 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		