Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VALHLTHCLOSE	A. BUILDING: _____ B. WING _____	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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 citations represent the findings of the licensure resurvey for the above named conducted on 07/22/2024.	S 000		
S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 10 residents with three residents included in the sample. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed based on the resident's "Functional Capacity Screen" (FCS), service needs, and preferences for resident (R)103.	S3085		

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

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S3085	Continued From page 1 Findings included: - Record review for R103 revealed he was admitted to the facility on 06/01/05. The 01/10/24 FCS identified R103 triggered for inappropriate behavior and impaired decision making. The 05/09/24 NSA failed to describe services R103 received for inappropriate behavior and impaired decision making. On 07/22/24 at approximately 03:51 PM Administrative Nurse B confirmed R103's NSA failed to describe the services provided for inappropriate behavior and impaired decision making. The administrator failed to ensure R103's NSA described the services he received based on his "FCS."	S3085		
S3213 SS=E	26-41-205 (g) (2) Medication Labeling (g) (2) Each prescription medication container shall have a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(2)	S3213		

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S3213	Continued From page 2 The facility reported a census of 10 residents. Based on observation and interview the administrator failed to ensure each prescription medication container had a label with the resident 's full name provided by a dispensing pharmacist affixed to the container. Findings included: - Observation on 07/22/24 at 12:51 PM revealed the facility's medication cart contained the following prescription medication containers which were not labeled with a resident's full name: Resident (R)102: One Wixela 250/50 inhaler disc R103: One albuterol sulfate HFA 90 microgram (mcg.) inhaler Four Stiolto Respimat 2.5 mcg inhaler On 07/22/24 at approximately 12:54 PM Licensed Nurse C confirmed that the six medications did not have labels affixed to the container with residents' full names. The administrator failed to ensure each prescription medication container had a label with the resident 's full name provided by a dispensing pharmacist affixed to the container.	S3213		
S3227 SS=E	26-41-205 (l) (2) Medication Regimen Review Variance Report (l) (2) The licensed pharmacist or licensed nurse	S3227		

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S3227	Continued From page 3 shall notify the medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist shall notify a licensed nurse within 48 hours of any variance identified in the resident ' s regimen review that does not require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident ' s medical care provider. The licensed nurse shall seek a response from the medical care provider within five working days of the medical care provider ' s notification of a variance. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l)(2) The facility reported a census of 10 residents with three residents included in the sample. Based on interview and record review the administrator failed to ensure a licensed nurse sought a response within five working days for variances found on pharmacy review for resident (R)102. Findings included: - Record review for R102 revealed an admission date of 02/07/15. The 01/31/24 "Consultant Pharmacist's Medication Regimen Review" for R102 documented a recommendation to evaluate benefit versus risk for the continued use of benztropine. A note was written to defer the evaluation to behavioral health. The 04/30/24	S3227		

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S3227	Continued From page 4 pharmacy review requested the response be put into the resident's electronic medical record. A note from the behavioral health provider dated 05/02/24 did not address this recommendation. R102's record lacked evidence the physician responded to the pharmacist's recommendation. On 07/22/24 at approximately 04:13 PM Administrative Nurse B confirmed R102's medical record lacked evidence a licensed nurse sought a response from the medical care provider regarding the variance within five working days. The administrator failed to ensure a licensed nurse sought a response from R102's medical care provider regarding the variance.	S3227		
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 10 residents. The facility had a main kitchen where food was stored and prepared. All residents eat food prepared in this kitchen. Based on observation and policy review the administrator failed to ensure food items were stored under safe	S3299		

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S3299	Continued From page 5	S3299		

conditions.

Findings included:

- Observation on 07/22/24 at 01:30 PM in the kitchen revealed a "reach in" refrigerator that contained food items for the residents. This space contained 9 individual containers of tartar sauce that lacked labels identifying a date the food was opened or prepared.

The facility's "Date Marking" policy dated 04/006/20 revealed that all ready to eat, potentially hazardous food will be dated when opened (and/or a Use by Date) and shall be used by safe food storage guidelines.

- Observation on 07/22/24 at 1:33 PM on top of deep freezer in back of kitchen was a tray with two packages of meat thawing at room temperature.

The facility's "Thawing Food" policy reveals food should be thawed with refrigeration, cool running water, microwave or part of the cooking process. Foods should never be thawed on a counter or at room temperature.

The August 2017 Kansas Department of Agriculture's "Focus on Food Safety" booklet Page 17 explains to never thaw foods at room temperature. On page 20, it explains that commercially prepared foods must be date marked after the original container was opened and held under refrigeration. Foods prepared on site must be labeled and date marked for consumption or discarded within 24 hours.

The administrator failed to ensure foods were

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S3299	Continued From page 6 stored under safe conditions.	S3299		