

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N047002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/20/2022
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PLACE LAKIN, KS 67860		
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S 000	INITIAL COMMENTS The following represent the findings of a resurvey for the above named Assisted Living facility conducted on 10/19/22 - 10/20/22.	S 000		
S3080 SS=E	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 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: 3080 26-41-201(a) The facility reported a census of 24 residents. The sample included three residents. Based on interview, and record review the operator failed to ensure the "Functional Capacity Screen" (FCS) for Resident (R)101 record findings for cognition. The operator also failed to ensure the FCS was completed before admission for R102 and failed to record findings for bladder	S3080		

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

TITLE

(X6) DATE

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S3080	Continued From page 1 incontinence, and cognition. Findings included: - R101's medical record revealed the resident moved into the facility on 03/31/22 with diagnoses of COPD. The 02/25/22 FCS failed to document R101's cognition status. On 10/20/22 at 10:46 AM Administrative Nurse A stated all sections of the FCS should be completed. The 09/2018 "Assisted Living Functional Capacity Screen" policy documented, " ...a Functional Capacity Screen will be completed on or prior to admission ...All information will be recorded to determine the individuals functional capacity on the facility form." The Operator failed to ensure all areas of R101's FCS were completed. - R102's medical record revealed the resident moved into the facility on 07/08/22 with a diagnosis of unstable macular degeneration. The 07/13/22 FCS was completed five days after R102 was admitted and failed to document R102's bladder incontinence status and her cognitive abilities. On 10/20/22 at 11:17 AM Administrative Nurse A stated the FCS should be completed prior to or upon admission and all sections of the FCS	S3080		

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S3080	Continued From page 2 should be completed. The 09/2018 "Assisted Living Functional Capacity Screen" policy documented, "...a Functional Capacity Screen will be completed on or prior to admission ...All information will be recorded to determine the individuals functional capacity on the facility form." The Operator failed to ensure R102's FCS was completed prior to or upon admission and all areas were completed.	S3080		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility 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: 3082 26-41-201(d) The facility reported a census of 24 residents. The sample included three residents. Based on interview, and record review the operator failed to ensure the "Functional Capacity Screen" (FCS) accurately reflected Resident (R)102's functional capacity for vision. Findings included: - R102's medical record revealed the resident	S3082		

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S3082	Continued From page 3 moved into the facility on 07/08/22 with a diagnosis of unstable macular degeneration. The 07/13/22 FCS failed to accurately identify R102's functional capacity for vision when it did not identify her as having macular degeneration. On 10/20/22 at 11:17 AM Administrative Nurse A stated all sections of the FCS should be completed accurately and R102's FCS did not trigger for vision even though she had visual limitations due to macular degeneration. The 09/2018 "Assisted Living Functional Capacity Screen" policy documented, "The administrator or operator will ensure that the functional capacity screen accurately reflects the resident's functional capacity at the time of the screening." The operator failed to ensure R102's FCS was completed accurately.	S3082		
S3085 SS=F	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	S3085		

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S3085	Continued From page 4 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: 3085 26-41-202(a) The facility reported a census of 24 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 fully developed on what triggered in the "Functional Capacity Screen" (FCS) for Resident (R)101, R102, and R103. Findings included: - R101's medical record revealed the resident moved into the facility on 03/31/22 with a diagnosis of COPD. The 02/25/22 FCS identified R101 triggered for impaired vision and impaired hearing. The 04/08/22 NSA did not address R101's impaired vision and impaired hearing. On 10/20/22 at 10:46 AM Administrative Nurse A stated if the FCS triggered for something it should be addressed on the NSA.	S3085		

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S3085	Continued From page 5 A policy for NSA was requested on 10/20/22 but the facility failed to provide one. The operator failed to ensure R101's NSA was fully developed to include all items that triggered on the FCS. - R102's medical record revealed the resident moved into the facility on 07/08/22 with a diagnosis of unstable macular degeneration. The 07/13/22 FCS identified R102 as having triggered for falls/unsteadiness and impaired decision-making. The 07/18/22 NSA did not address R102's triggers for falls/unsteadiness and impaired decision-making. On 10/20/22 at 11:17 AM Administrative Nurse A stated if the FCS triggered for something it should be addressed on the NSA. A policy for NSA was requested on 10/20/22 but the facility failed to provide one. The operator failed to ensure R102's NSA was fully developed to include all items that triggered in the FCS. -R103's medical record revealed the resident moved into the facility on 01/03/19 with a diagnosis of dementia. The 10/06/22 FCS identified R103 as having triggered for fall/unsteadiness and impaired decision-making.	S3085		

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S3085	Continued From page 6 The 10/13/21 NSA did not address R103's triggers for falls/unsteadiness and documented R103 did not present with any decision-making impairment. On 10/20/22 at 11:50 PM Administrative Nurse A stated if something triggered in the FCS it should be addressed on the NSA. A policy for NSA was requested on 10/20/22 but the facility failed to provide one. The operator failed to ensure R103's NSA was fully developed to include all items that triggered in the FCS.	S3085		
S3090 SS=E	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: 3090 26-41-202(C) The facility reported a census of 24 residents with three residents included in the sample. Based on interview, and record review the operator failed to ensure the development of an initial "Negotiated Service Agreement" (NSA) was completed at admission for Resident (R)101 and R102.	S3090		

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S3090	Continued From page 7 Findings included: - R101's medical record revealed the resident moved into the facility on 03/31/22 with a diagnosis of COPD. Review of 101's records revealed the most current NSA was signed and dated 04/08/22, eight days after R101 admitted to the facility. On 10/20/22 at 10:46 AM Administrative Nurse A stated the NSA should be completed upon admission. A policy for NSA was requested on 10/20/22 but the facility failed to provide one. The operator failed to ensure R101's NSA was developed at admission. - R102's medical record revealed the resident moved into the facility on 07/08/22 with a diagnosis of unstable macular degeneration. Review of 102's records revealed the most current NSA was signed and dated 07/18/22, ten days after R102 admitted to the facility. On 10/20/22 at 11:17 AM Administrative Nurse A stated the NSA should be completed upon admission. A policy for NSA was requested on 10/20/22 but the facility failed to provide one. The operator failed to ensure R102's NSA was	S3090		

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S3090	Continued From page 8 developed at admission.	S3090		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement 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; (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, facility 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: 3092 26-41-202(d)(1) The facility reported a census of 24 residents. The sample included three residents. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R)103 was reviewed and revised as needed at least once every 365 days. Findings included: - R103's medical record revealed the resident	S3092		

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S3092	Continued From page 9 moved into the facility on 01/03/19 with a diagnosis of dementia. The 10/06/22 "Functional Capacity Screen" (FCS) documented R103 had difficulty with both short-term and long-term memory, memory/recall and decision-making. Review of R103's records revealed the most current NSA was dated 10/13/21. On 10/20/22 at 11:50 AM Administrative Nurse A stated the NSA should be completed at least every 365 days. A policy for NSA was requested on 10/20/22 but the facility failed to provide one. The operator failed to ensure R103's NSA was reviewed and revised as needed at least once every 365 days.	S3092		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: 3101 KAR 26-41-202(h)	S3101		

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S3101	Continued From page 10 The facility reported a census of 24 residents. The sample included three residents. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R)101, and R102 was signed by all individuals involved in the development of the NSA to include the nurse responsible for the development of the NSA. Findings included: - R101's medical record revealed the resident moved into the facility on 03/30/22 with a diagnosis of COPD. The 04/08/22 NSA documented signatures for the resident and the operator/administrator but was not signed by the nurse who developed the NSA. On 10/20/22 at 10:46 AM Administrative Nurse A stated she believed the NSA should be signed by the operator and the resident or DPOA but wasn't aware she needed to sign the NSA as the nurse who developed the NSA. A policy concerning the NSA was requested on 10/20/22 but none was provided by the facility. The operator failed to ensure R101's NSA was signed by all individuals involved in the development of the NSA. - R102's medical record revealed the resident moved into the facility on 07/08/22 with a diagnosis of unstable macular degeneration.	S3101		

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S3101	Continued From page 11 The 07/18/22 NSA documented signatures for the resident and the operator/administrator but was not signed by the nurse who developed the NSA. On 10/20/22 at 11:17 AM Administrative Nurse A stated she believed the NSA should be signed by the operator and the resident or DPOA but wasn't aware she needed to sign the NSA as the nurse who developed the NSA. A policy concerning the NSA was requested on 10/20/22 but none was provided by the facility. The operator failed to ensure R102's NSA was signed by all individuals involved in the development of the NSA.	S3101		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: 3165 26-41-204(d) The facility reported a census of 24 residents with three residents included in the sample. Based on interview and record review the operator failed to ensure the "Negotiated Service	S3165		

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S3165	Continued From page 12 Agreement" (NSA) identified the licensed nurse responsible for the implementation and supervision of the health care services plan for Resident (R)102 and R103. Findings included: - R102's medical record revealed the resident moved into the facility on 07/08/22 with a diagnosis of unstable macular degeneration. R102's most recent NSA was completed on 07/18/22 and did not identify the nurse responsible for the implementation and supervision of the Health Care Service Plan (HCSP). On 10/20/22 at 11:17 AM Administrative Nurse A stated the nurse responsible for the implementation of the HCSP should be included on the NSA. A policy concerning the NSA was requested on 10/20/22 but none was provided by the facility. The operator failed to ensure the NSA identified the licensed nurse responsible for the implementation and supervision of the health care services plan for R102. - R103's medical record revealed the resident moved into the facility on 01/03/19 with a diagnosis of dementia. R103's most recent NSA was completed on 10/13/21 and did not identify the nurse responsible for the implementation and	S3165		

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S3165	Continued From page 13 supervision of the Health Care Service Plan (HCSP). On 10/20/22 at 11:50 AM Administrative Nurse A stated the nurse responsible for the implementation of the HCSP should be included on the NSA. A policy concerning the NSA was requested on 10/20/22 but none was provided by the facility. The operator failed to ensure the NSA identified the licensed nurse responsible for the implementation and supervision of the health care services plan for R103.	S3165		
S3211 SS=F	26-41-205 (g) (3) OVER THE COUNTER DRUGS (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: 3211	S3211		

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S3211	Continued From page 14 KAR 26-41-205 (g)(3) The facility reported a census of 24 residents. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package for all over-the-counter medications. A total of four containers of medications were not labeled with a resident name and was referred to as "stock" medications to be available for use for all residents as needed. Findings included: - Observation on 10/19/22 at 11:10 AM revealed Certified Medication Aide (CMA) B unlocked and opened a filing cabinet in the 300-hall library which contained the following over-the-counter medications that were not labeled with a resident's full name: One bottle of Tylenol Extra Strength (pain/fever) One bottle of Lutein 20 mg (eye supplement) One bottle of Vitamin D3 50 micrograms (supplement) One bottle of Equate Ibuprofen 200 milligrams (muscle relaxant/pain) On 10/19/22 at 11:10 AM CMA B stated the unlabeled bottles were used as "stock" medications. The 05/2021 "Medication Management: Orders, Labeling, and Storage" policy documented, "Over the counter medications ...A label will be printed off from the electronic medical record with	S3211		

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S3211	Continued From page 15 the residents full name present and placed on the container." The administrator failed to ensure all over-the-counter medications were labeled with a resident's full name.	S3211		
S3270 SS=F	26-41-104 (b) Written Emergency Plan (b) Each administrator or operator shall ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including the following: (1) Fire; (2) flood; (3) severe weather; (4) tornado; (5) explosion; (6) natural gas leak; (7) lack of electrical or water service; (8) missing residents; and (9) any other potential emergency situations. This REQUIREMENT is not met as evidenced by: 3270 KAR 26-41-104(b)(6)(8) The facility reported a census of 24 residents. Based on record review and interview for all residents and all facility employees, the operator failed to ensure the disaster and emergency plan include all required items as it failed to include information on missing persons and natural gas leak.	S3270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N047002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/20/2022
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PLACE LAKIN, KS 67860		
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S3270	Continued From page 16 Findings included: - On 10/19/22 review of documentation of the emergency management plan revealed it did not include information concerning missing residents, or natural gas leak. On 10/19/22 at 11:30 AM, Administrative Staff C acknowledged the disaster plan reviews did not include all required topics for review. The operator failed to ensure the emergency management plan included all the required items.	S3270		
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		

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S3280	Continued From page 17 This REQUIREMENT is not met as evidenced by: 3280 KAR 26-41-104(d)(3) The facility reported a census of 24 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 facility's emergency management plan with employees and residents. Findings included: - On 10/19/22 review of documentation of resident council meetings revealed the emergency management plan was reviewed with residents present at the meeting. These reviews did not include information concerning missing residents, or natural gas leak. These resident council meetings did not include all residents in the facility. On 10/19/22 at 11:30 AM, Administrative Staff C acknowledged the disaster plan reviews did not include all required topics for review. Email correspondence sent at 04:00 PM from Administrative Staff C stated she did not have documentation of staff education concerning the emergency management plan for the last two quarters of 2022. The operator failed to ensure quarterly reviews	S3280		

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S3280	Continued From page 18 of the emergency management plan with employees and staff were completed on a quarterly basis and included all the required items.	S3280		
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: 3310 KAR 26-41-207(c) The facility reported a census of 24 residents. The sample included three residents. Based on interview and record review for three residents and three new employee records, 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 K.A.R. 26-39-105. This failure	S3310		

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S3310	Continued From page 19 effected all residents who lived in the assisted living facility. Findings included: - Resident (R)101 moved into the facility on 03/31/22 with a diagnosis of COPD. Review of R101's medical record lacked evidence the resident had the second step of the two-step TB skin test (TST) completed. On 10/20/22 at 10:46 AM Administrative Nurse A stated only a one-step TST is completed for residents. The 06/2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "If the first TST is read as not positive, a second TST shall be administered within 1- 3 weeks." The operator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. - R102 moved into the facility on 07/08/22 with a diagnosis of unstable macular degeneration. Review of R102's medical record lacked evidence the resident had the second step of the two-step TB skin test (TST) completed. On 10/20/22 at 11:17 AM Administrative Nurse A stated only a one-step TST is completed for residents.	S3310		

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NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PLACE LAKIN, KS 67860		
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S3310	Continued From page 20 The 06/2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "If the first TST is read as not positive, a second TST shall be administered within 1- 3 weeks." The operator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. - Review of three newly hired employee files revealed the following: Review of facility personnel records revealed Certified Medication Aide (CMA) G was hired on 03/25/22 but lacked evidence a two-step TB skin test was completed. Review of facility personnel records revealed CMA B was hired on 06/23/22 but lacked evidence a two-step TB skin test was completed. On 10/19/22 at 10:10 AM Administrative Staff C stated the facility doesn't complete two-step TSTs on newly hired staff. The 09/2021 "Tuberculosis Control (Employee Health)" policy documented, "A two step PPD skin test is required for all ...AL employees." For two of three sampled residents (R101, R102) and two new employee record reviewed, the operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		