STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 represent the findings of a resurvey for the above named Assisted Living facility conducted on 07/05/22 - 07/07/22.	S 000		
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 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) The facility reported a census of 16 residents. The sample included three residents. Based on interview, and record review the operator failed to ensure the Negotiated Service Agreement included fall interventions, the use of a bed cane and compression hose for R706 and fall	S3085		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 1	S3085		

interventions and the use of a bed rail, for R707.

Findings included:

- Resident (R)706's medical record revealed he moved into the facility on 04/14/21 with a diagnosis of Type 2 diabetes mellitus.

The 04/12/22 "Functional Capacity Screen" (FCS) recorded R706 was independent with transfers and mobility and listed the use of a walker and wheelchair. The FCS did not document the use of a bed cane.

The 04/12/22 "Negotiated Service Agreement" (NSA) did not include documentation that R706 utilized a bed cane.

On 07/07/22 at 11:35 AM observed a bed cane properly attached to the right side of R706's bed.

Interview on 07/07/22 at 02:53 PM, Licensed Nurse (LN) B stated there was nothing in the NSA about the use of compression hose since she thought the use of compression hose would be temporary. LN B stated she did not include anything about the use of a bed rail in the NSA. LN B stated that fall interventions were not included in the Health Care Service Plan (HCSP).

The operator failed to ensure R706's NSA included the use of compression stockings and bed cane and failed to ensure the HCSP included fall interventions.

- Resident (R)707 moved to the facility on 06/14/21 and had diagnoses of mild cognitive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 2	S3085		

impairment, peripheral vascular disease, and pain.

The 05/19/22 "Functional Capacity Screen" (FCS) documented R707 was independent with transfers.

The 05/19/22 "Negotiated Service Agreement" (NSA) did not include the use of a bed rail, and did not include fall interventions.

06/28/22 "Side Rail Assessment" completed and included a justification for side rail use: "Family applied half rail to bed after...second fall from her bed."

06/30/22 "General Nursing Note" by Licensed Nurse (LN) B documented R707 was instructed to request assistance with ambulation in her room and reminder notes given.

On 07/06/22 at 01:25 PM observed a bed rail installed on the left side of the bed. There was a sign taped to the top of the bed rail, on the wall by the foot of the bed, on the bathroom door, and on a folding table beside the recliner reminding the resident to use her call light if she wanted to get up.

On 07/06/22 at 01:25 PM R707 stated after one of her falls the bed rail was installed.

On 07/06/22 at 1:56 PM LN B stated she has not added the bed rail to the NSA and didn't know if it actually needed to be added to the NSA. LN B stated she thought the extra help staff offered R707 and the reminder signs were only temporary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 3 On 07/07/22 at 03:20 PM LN B stated the bed rail and reminder signs were not included in the NSA but should be added to her NSA/HCSP. The operator failed to ensure R707's NSA included the use of a bed rail and fall interventions.	S3085		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 16 residents. The sample included three residents. Based on observation, interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for two of three sampled residents evidenced by the failure to complete and document an assessment for the purpose to use bed rails, ability to use bed rails safely without	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3155	Continued From page 4	S3155		

risk of entrapment, to confirm the bed rails were not a restraint for Resident (R)706, and failed to record all incidents, symptoms, and other indications of illness or injury for R705.

Findings included:

- R705's medical record revealed the resident moved into the facility on 05/25/21 with diagnoses of polyneuropathy, low back pain, and insomnia.

The 05/24/22 "Functional Capacity Screen" (FCS) documented R705 required supervision with treatments.

The 05/24/22 "Negotiated Service Agreement" (NSA) documented routine treatments would be administered by staff.

Review of the physician orders revealed no order for dressing changes or wound treatments.

07/28/21 "Skin Assessment" recorded a pressure wound on the sacrum. Assessment lacked a description or measurements. Document recorded an intervention of "self-treatment of coccyx wound."

06/24/22 "HCBS/FE Wellness Monitoring" documented R705 had pressure ulcers on bilateral buttocks.

No other documentation was found R705's medical record concerning pressure ulcers, time of origin, description of the wounds, measurements or plan for the treatment of these

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3155	Continued From page 5 wounds. On 07/06/22 at 11:05 AM R705 stated he has had some wounds on his buttocks for about five years prior to coming to this facility. Stated these wounds would heal and then open up again. Stated the nurse would change dressings on his bottom, mainly on shower days, and the nurse would let him know how the wounds were doing. On 07/06/22 at 10:18 AM Licensed Nurse (LN) B stated R705 had two pressure ulcers on his buttocks and either the Certified Medication Aide or the nurse would assist with dressing changes. LN B stated she did not assess or measure wounds unless R705 complained of pain, and stated the wound measurements were possibly documented under the skin assessment or in a nurses' notes. After looking through the medical chart LN B stated she may not have made a note after all and stated not everything has been documented but was kept in her memory. The 01/04/22 document "Assisted Living Skin Integrity Management Policy" recorded, "If the resident has, on admission, or develops pressure sore(s), resident will receive necessary and appropriate treatment and services to promote healing, prevent infection and prevent further development of additional impaired skin integrity ...The nursing team, including the physician will create a written plan for the treatment of impaired skin integrity which will be included in the resident's care plan ..." The operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services to meet the	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3155	Continued From page 6	S3155		

needs of R705 pressure ulcers.

- Resident (R)706's medical record recorded he moved into the facility on 04/14/21 with a diagnosis of Type 2 diabetes mellitus.

The 04/12/22 "Functional Capacity Screen" (FCS) documented R706 was independent with transfers and mobility and listed the use of a walker and wheelchair. The FCS did not document the use of a bed cane.

The 04/12/22 "Negotiated Service Agreement" (NSA) lacked documentation that R706 utilized a bed cane.

Review of R706's medical records failed to locate an assessment for the use of a bed cane.

On 07/07/22 at 11:35 AM observed a bed cane properly attached to the right side of R706's bed.

On 07/07/22 at 12:40PM Certified Medication Aide (CMA) H confirmed R706 had a bed cane which he used to help him reposition and get up from bed.

On 07/07/22 at 02:53 PM, Licensed Nurse (LN) B stated a side rail assessment had not been completed for R706.

The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for R706 regarding the use of a bed assistive device.

The operator failed to ensure a licensed nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3155	Continued From page 7 provided or coordinated the provision of necessary health care services to meet the needs for two of three sampled residents evidenced by the failure to complete and document an assessment for the purpose to use bed rails, ability to use bed rails safely without risk of entrapment, to confirm the bed rails were not a restraint for Resident (R)706, and failed to record all incidents, symptoms, and other indications of illness or injury for R705.	S3155		
S3166 SS=E	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: 26-41-204(e) The facility reported a census of 16 residents with three residents reviewed. Based on interview and record review the facility failed to ensure Certified Medication Aides (CMA) were trained and completed competencies for delegated nursing procedures to include dressing changes and insulin pen preparation for residents to self-administer. Findings included:	S3166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3166	Continued From page 8	S3166		

- Resident (R)705's medical record revealed the resident moved into the facility on 05/25/21 with diagnoses of polyneuropathy, low back pain, and insomnia.

The 05/24/22 "Functional Capacity Screen" (FCS) documented R705 required supervision with treatments.

The 05/24/22 "Negotiated Service Agreement" (NSA) documented routine treatments would be administered by staff.

Review of the physician orders revealed no order for dressing changes or wound treatments.

Review of the CMA Competency Packets for staff did not include competencies for staff to perform dressing changes or wound care.

On 07/07/22 at 12:30 PM Certified Medication Aide (CMA) H stated she changed R705's dressings at times and has received training and competency to do this.

On 07/06/22 at 10:18 AM Licensed Nurse (LN) B stated R705 had two pressure ulcers on his buttocks and either the CMA or the LN would assist with dressing changes.

On 07/07/22 at 02:53 PM, LN B stated R705 would at times request staff to dress his wounds and stated there wasn't a specific competency for dressing wounds that she completed for CMAs.

The operator failed to ensure designated staff completed competencies for performing dressing changes for R705.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3166	Continued From page 9 - Resident (R)706's medical record revealed he moved into the facility on 04/14/21 with a diagnosis of Type 2 diabetes mellitus. The 04/12/22 "Functional Capacity Screen" (FCS) documented R706 received Novolog insulin on a sliding scale with meals and Levemir insulin at bedtime. The 04/12/22 "Negotiated Service Agreement" (NSA) documented R706 self-administered insulin using insulin pen set up by nursing staff. An order dated 10/26/21 for Novolog FlexPen Solution Pen-injector 100 units/milliliter, inject as per sliding scale: if 0 - 130 = 0 units; 131 - 180 = 2 units; 181 - 240 = 4 units; 241 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 1000 = 0 units, subcutaneously with meals related to Type 2 diabetes mellitus. An order dated 04/18/22 for Levemir FlexTouch Solution Pen-injector 100 units/milliliter, inject 37 units subcutaneously at bedtime related to Type 2 diabetes mellitus. Review of the Certified Medication Aide (CMA) competency packets for staff, lacked competencies for preparing insulin for resident self-administration. On 07/07/22 at 11:35 AM R706 stated the CMA would dial up the insulin pen and would give the pen to resident to self-administer the insulin. On 07/07/22 at 12:40PM Certified Medication Aide (CMA) H stated the resident received	S3166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3166	Continued From page 10 insulin but he gave it to himself. CMA H stated that she dialed up the insulin pen, puts on the needle and then gave it to R706 to self-administer. CMA H stated she had been trained on how to dial-up the insulin pen. On 07/07/22 at 02:53 PM, Licensed Nurse (LN) B confirmed records lacked competency exams for CMAs preparing insulin pens for resident self-administration. The operator failed to ensure designated staff completed competencies for CMA's who prepared insulin pens for R705 to self-administer.	S3166		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually.	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3175	Continued From page 11 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 16 residents. The sample included three residents. Based on interview and record review the operator failed to ensure a Licensed Nurse (LN) completed a self-administration medication assessment for one of three sampled residents who self-administered some of their own medications. Findings included: - Resident (R)706's medical record revealed he moved into the facility on 04/14/21 with a diagnosis of: Type 2 diabetes mellitus. The 04/12/22 "Functional Capacity Screen" (FCS) documented R706 received Novolog insulin on a sliding scale with meals and Levemir insulin at bedtime. The 04/12/22 "Negotiated Service Agreement" (NSA) documented R706 will self administer insulin using insulin pen set up by nursing staff. An order dated 10/26/21 for NovoLOG FlexPen Solution Pen-injector 100 units/milliliter recorded: inject as per sliding scale: if 0 - 130 = 0 units; 131 - 180 = 2 units; 181 - 240 = 4 units; 241 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 1000 = 0 units, subcutaneously with meals related to Type 2 diabetes mellitus. An order dated 04/18/22 for Levemir FlexTouch Solution Pen-injector 100 units/milliliter recorded:	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3175	Continued From page 12 inject 37 units subcutaneously at bedtime related to Type 2 diabetes mellitus. On 07/07/22 at 11:35 AM R706 confirmed he received insulin and if the nurse was available he would ask her to administer the insulin. R706 also stated both the medication aide and the nurse would dial up the insulin pen and would give the pen to him to self-administer the insulin. On 07/07/22 at 12:40PM Certified Medication Aide (CMA) H stated R706 self-administered his insulin. On 07/07/22 at 02:53 PM, LN B stated R706 self-administered insulin at times. Resident's record lacked an assessment for self-injection of insulin. On 07/07/22 at 02:17 PM, LN B stated she did not have a medication self-administration assessment completed for R706 concerning insulin. The operator failed to ensure a medication self-administration assessment was completed for R706's use of insulin.	S3175		
S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the	S3186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3186	Continued From page 13 administration and management of selected medications. This REQUIREMENT is not met as evidenced by: 3186 KAR 26-41-205(b) The facility reported a census of 16 residents. The sample included three residents. Based on interview, and record review the operator failed to ensure the Negotiated Service Agreement/Health Care Service Plan for Resident (R)705 identified the responsible person for administration and management of selected medications the resident administered. Findings included: - R705's medical record revealed the resident moved into the facility on 05/25/21 with diagnoses of polyneuropathy, low back pain, and insomnia. The 05/24/22 "Functional Capacity Screen" (FCS) documented R705 self-administered Pregabalin, Trazadone and Norco. The 05/24/22 "Negotiated Service Agreement" (NSA) documented the facility administered all R705's medications and did not identify R705 self-administered Pregabalin, Trazadone and	S3186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3186	Continued From page 14 Norco. An order dated 06/30/21 Norco Tablet 7.5-325 milligrams (mg.), give one tablet by mouth every six hours as needed for pain related to low back pain. Unsupervised self-administration. An order dated 06/09/21 Pregabalin 150 mg., give one capsule by mouth three times daily related to polyneuropathy. Unsupervised self-administration. An order dated 06/09/21 for Trazodone HCL 100 mg., give one tablet by mouth at bedtime related to insomnia. Unsupervised self-administration takes when ready for bed. On 07/06/22 at 01:48 PM Certified Medication Aide (CMA) H stated R705 self-administered mainly as needed (PRN) medications and had a doctor's order for this. On 07/06/22 at 10:18 AM Licensed Nurse (LN) B stated R705 took his own Norco, Pregabalin and Trazadone. LN B stated the NSA should reflect these medications were self-administered. The Operator failed to ensure designated staff included select medications R420 self-administered in the NSA.	S3186		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3200	Continued From page 15 medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: 3200 KAR 26-41-205(d) The facility reported a census of 16 residents. Based on interview and record review, the operator failed to ensure that all medications were administered within professional standards of practice. The Licensed Nurse (LN) failed to follow policies and procedures and failed to follow standards of nursing practice designed to safeguard each patient. Staff failed to make sure medication administered exactly matched the physician's order recorded on the "Medication Administration Record" (MAR), and staff administering medications, inaccurately recorded medication administered for Resident (R)707. Findings included: - R707's medical record revealed he moved into	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3200	Continued From page 16	S3200		

the facility on 06/14/21 with a diagnosis of pain.

The 05/19/22 "Functional Capacity Screen" (FCS) documented R707 required staff assistance with medication administration.

The 05/19/22 "Negotiated Service Agreement" (NSA) documented staff administered medications for R707.

Physician's order dated 03/14/22 for Tylenol (no dose indicated) give two tablets by mouth every four hours as needed for pain/fever.

06/14/21 "Standing Medication Orders" for "Tylenol 500 milligrams (mg). 1-2 tab by mouth, every eight hours as needed. Do not exceed 3000 mg. daily.

The June 2022 "Electronic Medication Administration Record" (EMAR) recorded Tylenol, give two tablets by mouth every four hours as needed, was documented as administered 41 times between the dates of 06/20 and 06/30.

On 07/06/22 at 03:54 PM Certified Medication Aide (CMA) I stated R707 received Tylenol 500 mg, one tablet every four hours per the resident's request.

On 07/07/22 at 12:33PM CMA H stated R707 could have Tylenol 500 mg., one tablet every four hours.

On 07/06/22 at 03:40 PM, Licensed Nurse (LN) B stated the dose for Tylenol R707 received was 500 mg. and that she only received one tablet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3200	Continued From page 17 every four hours so her dose did not exceed 3000 mg per day. LN B stated the order should be changed to reflect the dose given. LN B stated there were only three staff that gave medications and she has told them to only give one tablet and that she doesn't have to write everything down since the staff know. The "Kansas Certified Medication Aide Curriculum" dated February 2011, p. 171 documented, "Make sure label on medication container matches exactly with the physician's order recorded on the MAR." The 2022 "Nurse Practice Act Statutes & Administrative Regulations" 60-3-110(c) on p.95 documented, "Unprofessional conduct. Any of the following shall constitute "unprofessional conduct":..failing to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard each patient..." The 01/04/22 "Assisted Living Physician Orders" policy documented, "Physician/Healthcare provider's plan of care must include ...Strength of drug/biological to be administered." The facility failed to ensure staff followed policies and procedures in the practice situation designed to safeguard each patient.	S3200		
S3248 SS=E	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration,	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3248	Continued From page 18 certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(3) The facility reported a census of 16 residents. Based on interview and record review of three newly hired employees, the operator failed to have evidence of nurse aide registry check at the time of hire for three of five employees reviewed. Findings included: - Review of "Certified Medication Aide" (CMA)	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3248	Continued From page 19 C's "Kansas Nurse Aide Registry" confirmation notice lacked a date when the facility checked the registry. Review of "Certified Nurse Aide" (CNA) E's "Kansas Nurse Aide Registry" confirmation notice lacked a date when the facility checked the registry. Review of CNA G's "Kansas Nurse Aide Registry" confirmation notice lacked a date when the facility checked the registry. On 07/05/22 at 03:20 PM, Administrative Staff A stated she was not aware of how to have the date print on the Nurse Aide Registry Confirmation Notice. The operator failed to provide evidence of when the nurse aide registry was contacted concerning newly hired employees.	S3248		
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	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 20 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 26-41-104(d)(3) The facility reported a census of 16 residents. Based on record review and interview for all residents and all faciliy employees, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan to with employees and residents to includ all topics. Findings included: - Review of the "Resident Council Meetings" documentation on 07/07/22 revealed the following: January 28, 2020- Reviewed emergency procedures individually. April 21, 2020- Went to resident's rooms and individually went over evacuation plans. July 15, 2020- Went to resident's rooms and individually went over evacuation plans. October 30, 2020- Went to resident's rooms and individually went over evacuation plans. January 14, 2021- Went to resident's rooms and individually went over evacuation plans. April 5, 2021- Went to resident's rooms and individually went over evacuation plans.	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 21 July 8, 2021- Went over evacuation plans individually. October 20, 2021- Went over evacuation plans during mealtime. January 19, 2022- Went over evacuation plans during mealtime. April 13, 2022- Went over evacuation plans individually. None of these reviews with residents included a list of residents this material was reviewed with. Staff Inservice going over all emergency policies reviewed for: 01/14/21 04/20/21 06/15/21- signature page not present. 09/16/21- signature page not present. 12/09/21- signature page not present. 03/16/22- signature page not present. 05/18/22- signature page not present. On 07/07/22 at 01:18 PM Adminstrative Staff A stated she didn't go over items with residents that she didn't think were pertinent to this facility and she didn't go over missing persons. Administrative Staff A stated with all her responsibilities at the facility providing a signature page for staff in-services went by the wayside. Stated she never has had a signature page or list of residents that she went over the evacuation plans with. The facility failed to ensure disaster and emergency preparedness by failing to perform quarterly reviews of the emergency management plan with all employees and residents and supply documentation of who took part in these reviews.	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 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 had a census of 16 residents. All 16 residents ate food prepared in the same kitchen. The operator failed to ensure food items were stored under safe and sanitary conditions by the failure to ensure foods stored in the refrigerator where kept at 41 degrees Fahrenheit (F) or lower according to Food Safety Guidelines. Findings included: - Observation on 07/06/22 at 02:13 PM of the kitchen revealed a double-doored refrigerator contained three plates of prepared food items individually covered with shrink wrap, numerous bottles of supplemental shakes and other food items. The internal temperature reading was 55 F. Review of the "Cooler Temperature" log for this refrigerator documented temperatures recorded on 07/05/22 in the morning of 50 F and in the evening of 57 F.	S3299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 23 On 07/06/22 at 02:18 PM, Administrative Staff A stated the double-door refrigerator in the kitchen was not working and wasn't supposed to be used. Administrative Staff A stated the refrigerator had to be refilled with freon in the past, but the temperatures recently started to rise again. The undated "Food Service Policy" documented, "Food will be stored in safe, sanitary conditions ..." According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017 the "Temperature DANGER ZONE is from 41 F to 135 F..." The operator failed to ensure food items were stored under safe and sanitary 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	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 24	S3310		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-207(c)

The facility reported a census of 16 residents. The sample included three residents. Based on interview and record review for three residents and five new employee records, the operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference K.A.R. 26-39-105. This failure effected all residents who lived in the assisted living facility.

Findings included:

- Review of five newly hired staff records revealed the following:
Certified Medication Aide (CMA) C hired on 12/17/20 had a two-step Tuberculosis (TB) skin test completed in 10/2018- 11/2018 which was over two years prior to being hired.

Licensed Nurse (LN) D hired on 05/06/21 and completed a "Tuberculosis Symptom Screen Questionnaire" on 11/30/21 which was more than six months after the date of hire.

Certified Nurse Aide (E) hired on 11/20/21 had a two-step TB skin test and a "Tuberculosis Symptom Screen Questionnaire" completed on 05/2019 which was over two years prior to the date of hire.

LN F hired on 11/28/21 lacked a "Tuberculosis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 25 Symptom Screen Questionnaire" completed with seven days of employment. Review of the TB guidelines for adult care homes dated June 2013 revealed each new resident and new employee shall have an initial TB symptom questionnaire completed and receive a two-step TB skin test within seven days of residency or employment. On 07/05/22 at 03:20 PM, Administrative Staff A stated it was her expectation that a TB Screening Questionnaire and a two-step TB skin test be completed on all new hires. The undated "Tuberculosis Testing Policy" documented, "Skin testing will be done on all new residents and employees as soon as their residency or employment begins. Testing should be performed within the first 7 days of residency or employment." The operator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KA.R. 26-39-105.	S3310		