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 _____	12/12/2023

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 citations represent the findings of a Re-Licensure survey for the above named Assisted Living facility conducted on 12/11/23 and 12/12/23.	S 000		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201 (c)(1) The facility reported a census of 14 residents (R). The sample included three residents. Based on interview and record review the operator failed to ensure staff completed a "Functional Capacity Screen" for one (R3) of three sampled residents at least every 365 days. Findings Included: - Review of R3's "Electronic medical record" (EMR) revealed she moved into the facility on 04/02/22 with diagnoses of : hypertension, chronic kidney disease, and heart disease.	S3081		

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 _____	12/12/2023

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
S3081	Continued From page 1 R3's EMR included "Functional Capacity Screens" (FCS) dated 04/04/22 and 10/27/22. The Licensed Nurse had not completed a FCS since 10/27/22, more than 365 prior. On 12/11/23 at 01:10 PM Licensed Nurse B reviewed R3's EMR and confirmed she failed to complete her FCS within 365 days of the prior FCS. Review of the " Assisted Living Functional Capacity Screen" policy provided by Operator A directed staff ro conduct a screening at least once every 365 days. The operator failed to ensure designated staff completed R3's FCS at least every 365 days.	S3081		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the 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	S3085		

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 _____	12/12/2023

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 payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a)(2) The facility reported a census of 14 residents (R). The sample included three residents. Based on record review and interview for two (R3 and R5) of three sampled residents, the operator failed to ensure a licensed nurse completed the "Negotiated Service Agreement" based on the resident's "Functional Capacity Screen" and service needs including a description of the service to be provided and who provided the service. Findings included: - Review of R3's "Electronic Medical Record" revealed she moved into the facility on 04/02/23 with diagnoses of hypertension, chronic kidney disease, heart disease. R3's most current "Functional Capacity Screen" (FCS) dated 10/27/22 revealed she had current problems with falls/unsteadiness, impaired vision and hearing, and wandered. R3's "Negotiated Service Agreement" (NSA) dated 01/03/23 failed to identify services or who would provide the services related to falls, impaired vision and hearing and the residents wandering. It also failed to include that the resident had a lift chair and U-bar (bed cane) attached to her bed to use as an assistive	S3085		

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 _____	12/12/2023

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	S3085		

device.

On 12/12/23 at 01:23 PM Licensed Nurse (LN) B reviewed the NSA and acknowledged it did not include the resident's use of a lift chair or that she had a U-bar on her bed. LN B also acknowledged it did not address services related to falls, impaired vision and hearing or the residents wandering.

The operator failed to ensure designated staff developed R3's NSA to include services and the provider of services based upon R3's FCS and service needs.

- Review of R5's "Electronic Medical Record" revealed he moved into the facility on 04/14/21 with diagnoses of type II diabetes mellitus and heart failure.

R5's "Functional Capacity Screen" (FCS) dated 02/17/23 identified he needed physical assistance with management of medications and medical treatments, had bladder incontinence and current problems or at risk for falls.

R5's "Negotiated Service Agreement" (NSA) dated 02/17/23 failed to specify the CMA monitored the residents blood glucose and prepared/dialed the resident's insulin pen to the correct dosage and then the resident self-injected the insulin. It also failed to address services related to bladder incontinence and falls.

On 12/12/23 at 03:59 PM Licensed Nurse (LN) B acknowledged the NSA did not include services or who provided services for R5 related to the

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 _____	12/12/2023

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 4 delegated procedure for preparing his insulin and checking his blood glucose or services related to falls and bladder incontinence. The operator failed to ensure designated staff developed R5's NSA to include services and the provider of services based upon R5's FCS and service needs.	S3085		
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: KAR 26-41-202 (d)(2) The facility reported a census of 14 residents (R). The sample included three residents. Based on observation, interview and record review the operator failed to ensure designated staff reviewed and revised the "Negotiated Service	S3092		

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 _____	12/12/2023

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
S3092	Continued From page 5	S3092		

Agreement" for one (R3) of three sampled residents when the resident experienced a significant change in status related to an increased need for assistance activities of daily living.

Findings included:

- Review of R3's "Electronic medical record" (EMR) revealed she moved into the facility on 04/02/22 with diagnoses of hypertension, chronic kidney disease, and heart disease.

R3's most current "Functional Capacity Screen" (FCS) dated 10/27/22 identified the resident required physical assistance with bathing, dressing, had impaired cognition, was at risk for falls, had wandering and impaired vision, hearing and decision-making ability.

R3's most current "Negotiated Service Agreement" (NSA) dated 01/03/23 did not include services related to needing assistance with toileting or transfers, with bladder incontinence or with inappropriate behaviors.

R3's EMR included an amended NSA dated 12/01/23 related to increased edema and weeping lower extremities with local outside resources tto provide wound care and Occupational therapy for lymphedema massage.

Review of Physicians orders revealed the following:
01/12/23 - Home Health (HH) physical therapy to evaluate and treat for steadiness of gait strengthening.
04/03/23 - occupational therapy from HH to

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 _____	12/12/2023

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
S3092	Continued From page 6	S3092		

provide interventions for lymphedema and provide wound care.
06/28/23 - request sent to have HH evaluate and treat open areas where legs are weeping.
11/21/23 - HH consult for wound care.

R3's progress notes from April 10, 2023 to current, included multiple entries the resident wandered the halls trying to leave the facility, went into other resident's rooms, and included medication changes related to R3's increased behaviors. It also included entry that the resident had declined in functional status and needed more assistance of staff.

On 12/12/23 at 11:14 AM Certified Medication Aide C reported R3 has had a decline and is needing more help in the bathroom, with dressing and showers.

On 12/12/23 at 03:36 PM Certified Nurse Aide (CNA) F reported the resident can be aggressive when she doesn't want something done, so we come back later and try again. R3 is incontinent and we need to help change her brief and do incontinent care and she will go into other resident rooms and try to get them to talk to her and think their room is her room.

On 12/12/23 at 01:15 PM Licensed Nurse (LN) B reviewed the residents chart looking for Amended NSAs. LN B confirmed the resident received HH services for wound care off and on this past year and should have completed an amended NSA when they stopped and restarted services. LN B also acknowledged the resident had declined in her functional ability and is requiring a lot more assistance and monitoring

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 _____	12/12/2023

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
S3092	Continued From page 7 from staff. The operator failed to ensure designated staff reviewed and revised R3's NSA when she had changes in outside services and a decline in functional ability.	S3092		
S3166 SS=D	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: KAR 26-41-204(e) The facility reported a census of 14 residents. Based on interview and record review the administrator failed to ensure two of two sampled Certified Medication Aides (CMA) were trained by a licensed nurse and delegated the nursing procedure for obtaining blood glucose checks according to the nurse practice act and amendments thereto. Findings included: - On 12/11/23 at 11:45 AM Operator A provided newly hired employee files for review. On 12/11/23 at 11:50 PM surveyor requested	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 _____	12/12/2023

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 delegation/competency checks for blood glucose monitoring for Certified Medication Aide (CMA) D hired on 08/30/23 and CMA E hired on 11/18/22. On 12/11/23 at 11:55 AM LN B reported CMA E only worked once a month and did not have the delegation for checking blood sugars. On 12/11/23 at 12:14 PM LN B provided delegation papers for CMA D dated 11/27/23. LN B acknowledged CMA D had checked the resident's blood glucose prior to completing his delegation on the task. Review of the "Delegation of Nursing Tasks to Direct Care Partners" dated 02/01/23 the LN may delegate nursing tasks that are not included in the state mandated training program as long as the "Direct Care Partner" has been found to be competent to do so. The operator failed to ensure the LN delegated the nursing task of monitoring a resident's blood glucose, which is not included in the CMA curriculum, for two of two newly hired CMAs who had monitored the resident's blood glucose.	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	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 _____	12/12/2023

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 9 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. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 14 residents. The sample included three residents. Based on observation, interview, and record review the administrator failed to ensure a licensed nurse completed an assessment for self-injection of insulin for R4 at least annually that showed he was capable of self-injection of insulin at least annually. Findings included: -- Review of R5's "Electronic Medical Record" (EMR) revealed he moved into the facility on 04/14 with diagnosis of type II diabetes. R5's "Functional Capacity Screen" dated 02/17/23 revealed the resident needed physical assistance with management of medications. R5's "Negotiated Service Agreement" dated 02/17/23 revealed Nursing staff will dial insulin pens and manage medication administration.	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 _____	12/12/2023

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 10 Review of R5's EMR include a self-administration assessment for the resident's ability to self inject his insulin dated 07/22/22. On 12/11/23 at 12:01 PM Certified Medication Aide (CMA) C reported R5 received insulin and the staff prepare it and dialed to the ordered dosage and then he self-injected the insulin. Observation on 12/12/23 ay 12:30 PM CMA C staff dialed R5's insulin pen to two units to prime the pen and then dialed it to four units and handed it to the resident. He took the pen and poked his abdomen, pushed the plunger, and then handed the pen back to the CMA. On 12/12/23 at 04:03 PM Licensed Nurse B looked through R5's EMR and acknowledged she had not completed an assessment for his ability to self-inject his insulin since 07/22/22. The operator failed to ensure a licensed nurse completed an assessment for self-injection of insulin after staff prepared the pen at least annually.	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 administration and management of selected	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 _____	12/12/2023

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 11 medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (b) The facility reported a census of 14 residents(R). The sample included three residents. Based on observation, interview, and record review the administrator failed to ensure one (R5) of one sampled residents who self-injected their insulin, had a Negotiated Service Agreement that identified the responsible person for the administration and management of his insulin. Findings included: -- Review of R5's "Electronic Medical Record" (EMR) revealed he moved into the facility on 04/14 with diagnosis of type II diabetes. R5's "Functional Capacity Screen" dated 02/17/23 revealed the resident needed physical assistance with management of medications. R5's "Negotiated Service Agreement" (NSA) dated 02/17/23 revealed Nursing staff will dial insulin pens and manage medication administration. R5's NSA failed to identify the resident self-injected his insulin and the facility staff administered all other medications.	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 _____	12/12/2023

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 12 On 12/11/23 at 12:01 PM Certified Medication Aide (CMA) C reported R5 received insulin and the staff prepare it and dialed to the ordered dosage and then he self-injected the insulin. Observation on 12/12/23 ay 12:30 PM CMA C staff dialed R5's insulin pen to two units to prime the pen and then dialed it to four units and handed it to the resident. He took the pen and poked his abdomen, pushed the plunger, and then handed the pen back to the CMA. On 12/12/23 at 03:39 PM Licensed Nurse B looked at R5's NSA and confirmed it did not specify the resident self injected his insulin and staff administered the rest of his medications. The operator failed to ensure designated staff completed R5s NSA to identify the selected medications that resident chose to self-inject.	S3186		
S3202 SS=D	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(4) The facility reported a census of 14 residents. Based on interview and record review the administrator failed to ensure two of two sampled	S3202		

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 _____	12/12/2023

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
S3202	Continued From page 13 Certified Medication Aides (CMA) were trained by a licensed nurse and delegated the nursing procedure of preparing and dialing an insulin pen to the ordered dosage for a resident to then self-inject, which is not a part of the CMA curriculum. Findings included: - Review of the resident roster provided on 12/11/23 revealed one resident received insulin injections. During an interview on 12:29 PM Operator A reported either the Certified Medication Aide (CMA) prepared and dialed the resident's insulin pen to the correct dosage and the resident self-injected it or the Licensed Nurse (LN) administered the insulin. On 12/11/23 at 11:45 AM Operator A provided newly hired employee files for review. On 12/11/23 at 11:50 PM surveyor requested delegation/competency checks for preparing and dialing insulin pens for Certified Medication Aide (CMA) D hired on 08/30/23 and CMA E hired on 11/18/22. On 12/11/23 at 11:55 AM LN B reported CMA E only worked once a month and did not have the delegation for preparing and dialing insulin pens to the ordered dosage completed. On 12/11/23 at 12:14 PM LN B provided delegation papers for CMA D dated 11/27/23. LN B acknowledged CMA D had prepared the insulin pen for the resident to self-inject prior to	S3202		

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 _____	12/12/2023

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
S3202	Continued From page 14 completing his delegation on the procedure. Review of the "Delegation of Nursing Tasks to Direct Care Partners" dated 02/01/23 the LN may delegate nursing tasks that are not included in the state mandated training program as long as the "Direct Care Partner" has been found to be competent to do so. The operator failed to ensure the LN delegated the nursing procedure of preparing and dialing the dosage of an insulin pen, which is not included in the CMA curriculum, to two of two newly hired CMAs who had prepared insulin pens for the resident to self-inject.	S3202		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store	S3215		

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 _____	12/12/2023

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
S3215	Continued From page 15	S3215		

medications in a place that is accessible only to the resident, licensed nurses, and medication aides.
(3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility.
(4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-205(h)(4)

The facility reported a census of 14 residents. Based on observation, interview, and record review the administrator failed to ensure a licensed nurse did not administer Tuberculin Skin Test Antigens beyond the manufacturer's recommended date of expiration.

Findings included:

- During initial tour on 12/11/23 at 12:01 PM Certified Medication Aide C unlocked the medication room for investigation for medication storage. Observation of the medication storage refrigerator contained 1 vials of Tuberculin. The vial did not have a date it was opened on it.

On 12/11/23 at 12:04 PM Licensed Nurse (LN) B acknowledged the vial needed to have a 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 _____	12/12/2023

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
S3215	Continued From page 16 written on it and stated it was "probably too old". Per Tubersol package directions noted a vial of Tubersol which has been entered and in use for 30 days should be discarded. The operator failed to ensure a LN dated when the Tubersol vial had been initially entered to ensure the LN did not administer Tuberculin Skin Test Antigens beyond the manufacturer's recommended date of expiration.	S3215		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 14 residents (R). The sample included three residents. Based on interview and record review the operator failed to ensure two (R3 and R5) of three sampled residents records contained documentation of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken. Findings included:	S3261		

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 _____	12/12/2023

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
S3261	Continued From page 17	S3261		

- Review of R3's "Electronic Medical Record" revealed she moved into the facility on 04/02/23 with diagnoses of hypertension, chronic kidney disease, heart disease.

R3's most current "Functional Capacity Screen" (FCS) dated 10/27/22 revealed she was unable to manage medications and medical treatments, had current problems with falls/unsteadiness, impaired vision and hearing, and wandered.

R3's "Negotiated Service Agreement" (NSA) dated 01/03/23 identified the nursing staff managed medications and medical treatments.

Review of R3's electronic record included the following progress notes:
05/23/23 discussed resident's increased agitation, wandering, going into other resident apartments and exit seeking with family and they questions if need to increase the residents antidepressant.
05/25/23 new order to increase the resident's antidepressant.
05/26/23 new order to schedule the resident's antianxiety medications.
The record lacked documentation of the residents' behaviors as discussed with the family prior to 05/23/23 or what interventions staff tried related to the behaviors. It also lacked follow up as to how the increased and scheduled medications effected the resident's behaviors.
06/15/23 the record noted the resident had increased behaviors over the past week and difficulty for staff to handle. New order for Seroquel, an antipsychotic to be administered daily.
The record lacked documentation of how the

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 _____	12/12/2023

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
S3261	Continued From page 18	S3261		

behaviors had increased and were difficult for staff to handle. It also lacked follow-up on the effectiveness of the Seroquel related to the resident's behaviors.

An interview on 12/12/23 at 03:36 PM Certified Nurse Aide F reported the resident can get aggressive with cares and so staff have to leave and return later to try again.

On 12/12/23 at 01:36 PM Licensed Nurse B reported she knew she had not documented as she should have related to the resident's behaviors.

The operator failed to ensure the Licensed Nurse documented R3's behaviors and interventions staff attempted prior to the increase of antianxiety and the initiation of antipsychotic medications and did not follow up on the effectiveness of the medications.

- Review of R5's "Electronic Medical Record" revealed he moved into the facility on 04/14/21 with diagnoses of type II diabetes mellitus and heart failure.

R5's "Functional Capacity Screen" dated 02/17/23 revealed the resident required physical assistance with medications and medical treatments.

R5's "Negotiated Service Agreement" dated 02/17/23 identified nursing staff dialed insulin pens and managed the administration of medications and treatments.

Review of R5's electronic progress notes

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 _____	12/12/2023

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
S3261	Continued From page 19 included the following documentation: On 05/02/23 Fax received from hospice for anxiolytic (drug used to reduce anxiety). The record lacked documentation of why the medication was initiated or follow up related to the effectiveness of the medications. 07/28/23 resident complained of not able to sleep and order to increase Ambien (sleeping pill). The record lacked follow up related to the effectiveness of the increase dosage of Ambien. On 10/19/23 resident reported increased anxiety and new order to schedule Hydroxyzine (antianxiety) three times a day to see if it helps resident to feel better. The record lacked follow-up on the effectiveness of the mediations. On 12/12/23 at 04:01 PM Licensed Nurse B reported the resident has had anxiety forever and did not really think much about the medications changes but acknowledged she should have followed up if the changes in medications were effective. The operator failed to ensure the Licensed Nurse documented the follow up for effectiveness of antianxiety medication changes.	S3261		
S3280 SS=E	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;	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 _____	12/12/2023

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 (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. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 14 residents. Based on record review and interview for all employees, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly reviews of the facility's emergency management plan with all employees. Findings included: - On 12/11/23 Operator A provided a notebook to review for reviewing the emergency management plan with employees. Review of the notebook revealed the operator had divided the eight required emergencies to be reviewed during different months. The record showed that Severe Weather and Tornado were not reviewed the first or third quarter of 2023. Loss of electrical services/water service, natural	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 _____	12/12/2023

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 gas leak, flood and explosion were not reviewed the first quarter of 2023. On 12/11/23 at 01:26 PM Operator A acknowledged she had not reviewed each area at least quarterly with employees. The operator failed to ensure the facility's emergency management plan which included all eight required possible emergencies was reviewed with all residents and employees quarterly.	S3280		
S3420 SS=F	28-39-256 MECHANICAL REQUIREMENTS (c) Mechanical requirements. (1) Heating, air conditioning, and ventilating systems. (A) The system shall be designed to maintain a year-round indoor temperature range of 70oF or 21oC to 85oF or 26oC. (B) Each apartment or individual living unit shall allow the resident to control the temperature. (2) Plumbing and piping systems. (A) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (B) Water distribution systems shall be arranged to provide hot water at outlets at all times. The temperature of hot water shall range between 98oF and 120oF at bathing facilities,	S3420		

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 _____	12/12/2023

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
S3420	Continued From page 22 sinks, and lavatories in resident use areas. (3) Electrical requirements. (A) All spaces occupied by persons or machinery and equipment within the buildings, approaches to buildings, and parking lots shall have adequate lighting. (B) Minimum lighting intensity levels shall be as required in Table 1. (C) Each corridor and stairway shall remain lighted at all times. (D) Each light in resident use areas shall be equipped with shades, globes, grids, or glass panels. This REQUIREMENT is not met as evidenced by: KAR 28-39-256(c)(2)(B) The facility reported a census of 14 residents. Based on observation, and interview the operator failed to ensure the temperature of hot water in the public restroom by the dining room that is accessible to residents, ranged between 98 degrees Fahrenheit (F) and 120 degrees F according to regulatory guidelines. Findings included: - During initial tour on 12/11/23 at 01:34 PM surveyor checked the hot water temperature in the unlocked public restroom by the dining room. The temperature read 123 degrees Fahrenheit	S3420		

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 _____	12/12/2023

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
S3420	Continued From page 23 (F) right away and then quickly climbed to 137.9 and stabilized. On 12/11/23 at 01:38 PM Licensed Nurse B got a thermometer from the kitchen and checked the temperature. Within one minute the thermometer read 135 degrees F and stabilized. On 12/11/23 at 02:01 PM Administrative staff A checked the hot water temperature in the public restroom with a different digital thermometer and it immediately went up to 133 degrees F and continued to climb to 135.7 degrees F and stabilized. Review of the monthly water temperatures log for 2023 revealed all temperatures were 117.6 or lower and within range. Review of the "Monitoring Water Temperatures" policy dated 02/01/23, revealed hot water at sinks, tubs, and showers used by residents will be maintained between 110 degrees F and 120 degrees F. The operator failed to ensure hot water temperatures in areas accessible to residents remained within regulator guidelines of 98 to 120 degrees F.	S3420		