STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint numbers 175778, 174367, 172687, and 172427, for the above named facility conducted on 02/06, 02/07, and 02/08/2023.	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: K.A.R 26-41-201 (c) (1) The facility reported a census of 12 residents. The sample included 3 "Residents'" (R's 1, 2, and 3). Based on interview and record review the operator failed to ensure a "Functional Capacity Screen" (FCS)was performed at least once every 365 days for R1 and R3. Findings included: - Record review on 02/07/23 for R1 revealed an admission date of 01/04/22 with diagnoses of chronic obstructive pulmonary disease, celiac	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
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 disease, atrial fibrillation, abdominal aortic aneurysm, generalized anxiety, hypothyroidism, hypertension, and morbid obesity due to excess calories. Record review of R1 FCS dated 01/16/22 revealed the resident required physical assistance with bathing, and dressing. She was independent with toileting, walking, and eating. She required supervision with her medications and her cognition was intact. She was able to make herself understood and she understood others. She was marked with falls and impaired vision and used a walker mobility device. R1 FCS was greater than 365 days old. - Record review on 02/02/23 for R3 revealed an admission date of 01/17/22, with diagnoses of end stage renal disease, dependence on renal dialysis, history of falling, atherosclerotic heart disease, presence of coronary angioplasty implant and graft, long term use of antithrombotic and anti-platelets, type 2 diabetes, and long-term use of insulin. Record review of R3 FCS dated 01/18/22 identified the resident required supervision with bathing. He was independent with dressing, toileting, transferring, walking, and eating. He lacked the ability to manage his own medications, and was marked with falls, impaired vision, and impaired hearing. His cognition was intact, and he was able to make himself understood and he understood others. He used no mobility device.	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 2 R3 FCS was greater then 365 days old. Interview on 02/08/23 at 02:55 PM with Operator A and Regional Licensed Nurse B, they confirmed the FCS's for R1 and R3 were greater then 365 days old. The operator failed to ensure a "Functional Capacity Screen" (FCS)was performed at least once every 365 days for R1 and R3.	S3081		
S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: K.A.R 26-41-202 (a)	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 The facility reported a census of 12 residents. The sample included 3 "Residents'" (R's 1, 2, and 3). Based on interview and record review the operator failed to ensure the development of a written" Negotiated Service Agreement" (NSA) for each resident, based on the resident's "Functional Capacity Screen" (FCS) that had been performed at least once every 365 days for R1 and R3. Findings included: - Record review on 02/07/23 for R1 revealed an admission date of 01/04/22 with diagnoses of chronic obstructive pulmonary disease, celiac disease, atrial fibrillation, abdominal aortic aneurysm, generalized anxiety, hypothyroidism, hypertension, and morbid obesity due to excess calories. Record review of R1 FCS dated 01/16/22 revealed the resident required physical assistance with bathing, and dressing. She was independent with toileting, walking, and eating. She required supervision with her medications and her cognition was intact. She was able to make herself understood and she understood others. She was marked with falls and impaired vision and used a walker mobility device. Record review of R1 combined NSA/ "Health Service Plan" (HSP) dated 01/11/2023 instructed staff to provide the following health care services: assist R1bathing her lower body, putting on her shoes. - Record review on 02/02/23 for R3 revealed an	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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	S3085		

admission date of 01/17/22, with diagnoses of end stage renal disease, dependence on renal dialysis, history of falling, atherosclerotic heart disease, presence of coronary angioplasty implant and graft, long term use of antithrombotic and anti-platelets, type 2 diabetes, and long-term use of insulin.

Record review of R3 FCS dated 01/18/22 identified the resident required supervision with bathing. He was independent with dressing, toileting, transferring, walking, and eating. He lacked the ability to manage his own medications, and was marked with falls, impaired vision, and impaired hearing. His cognition was intact, and he was able to make himself understood and he understood others. He used no mobility device.

Record review of R3 combined NSA/ "Health Service Plan" (HSP) dated 01/17/23, instructed staff to provide the following health care services: R3 could require stand by assist for bathing, R3 would ask for help if needed. Staff to physical assist with medication administration, and check resident blood sugar prior to meals, at bedtime, and as needed.

Interview on 02/08/23 at 02:55 PM with Operator A and Regional Licensed Nurse B, they confirmed the NSA's for R1 and R3 were not based on a current FCS that had been performed at least once every 365 days.

The operator failed to ensure the development of a written "Negotiated Service Agreement" (NSA) for each resident, based on the resident's "Functional Capacity Screen" (FCS) that had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 5 been performed at least once every 365 days for R1 and R3.	S3085		
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: K.A.R. 26-41-204 (e) The facility reported a census of 12 residents. Based on interview and record review the operator failed to ensure the" Licensed Nurse" (LN) documented the delegation of the nursing procedure of dialing an insulin pen, to the facility "Certified Medication Aide's" (CMA's), respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto for newly hired CMA's E and F. Findings included: - Interview with Operator A on 02/06/22 at approximately 04:30 PM during the completion of the departments "Entrance Tour Checklist", she revealed the "Certified Medication Aide's" (CMA'S) dial the insulin pens for the residents, and the residents self-inject the insulin.	S3166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 6 Record Review on 02/07/23 of the facility provided "Resident Roster" revealed two resident's received insulin injections. Record review of newly hired CMA E revealed she began employment on 01/31/23. The personnel record lacked the nursing delegation documentation for how to dial the insulin pen. Record review of newly hired CMA F revealed she began employment on 10/20/22. The personnel record lacked the nursing delegation documentation for how to dial the insulin pen. Interview on 02/07/23 at 11:20 AM with Operator A and Regional Licensed Nurse B confirmed the newly hired CMA personnel records lacked the documentation for the delegation for how to dial the insulin pens. Record review 02/08/23 of facility provided training titled "Insulin Pen Training" was completed on 02/08/23 and signed by CMA's E and F The operator failed to ensure the" Licensed Nurse" (LN) documented the delegation of the nursing procedure of dialing an insulin pen, to the facility "Certified Medication Aide's" (CMA's), respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto for newly hired CMA's E and F.	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	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 7 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. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (a) The facility reported a census of 12 residents. The sample included 3 "Residents'" (R's 1, 2, and 3) and 4 focused reviews (R's 5, 6, and 7). Based on interview and record review the operator failed to ensure the "Licensed Nurse" (LN) performed an assessment determining R3 could safely and accurately self-inject his insulin without staff assistance. Findings included: - Interview with Operator A on 02/06/22 at approximately 04:30 PM during the completion of the departments "Entrance Tour Checklist", she revealed the "Certified Medication Aide's" (CMA'S) dial the insulin pens for the residents,	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 8	S3175		

and the residents self-inject the insulin.

Record Review on 02/07/23 of the facility provided "Resident Roster" revealed R3 received insulin injections.

02/02/23 Record review for R3 revealed an admission date of 01/17/22, with diagnoses of end stage renal disease, dependence on renal dialysis, history of falling, atherosclerotic heart disease, presence of coronary angioplasty implant and graft, long term use of antithrombotic and anti-platelets, type 2 diabetes, and long-term use of insulin.

Record review of R3 "Functional Capacity Screen" (FCS) dated 01/18/22 identified the resident required supervision with bathing. He was independent with dressing, toileting, transferring, walking, and eating. He lacked the ability to manage his own medications, and was marked with falls, impaired vision, and impaired hearing. His cognition was intact, and he was able to make himself understood and he understood others. He used no mobility device.

Record review of R3 combined "Negotiated Service Agreement" (NSA)/ "Health Service Plan" (HSP) instructed staff to provide the following health care services: R3 could require stand by assist for bathing, R3 would ask for help if needed. Staff to physical assist with medication administration, and check resident blood sugar prior to meals, at bedtime, and as needed.

Record review of R3 "Electronic Medication Administration Record" revealed the following order:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 NovoLOG Solution (Insulin Aspart) inject as per sliding scale: If 60-179=0 180-200=1 unit 201-260=2 units 261-330=3 units 331-390=4units 391-450=5units 451-500=6units If blood sugar is greater than 500 call the doctor. Subcutaneously every 4 hours as needed for hyperglycemia related to Type 2 Diabetes Mellitus with Hyperglycemia, supervised self - administration. Give as needed at 0630, 1100, and 1600 prior to meals. Order date 09/26/22. The electronic resident record lacked an assessment which confirmed that R3 could safely and accurately self-inject his insulin without staff assistance. Interview on 02/08/23 at 01:42 PM with R3, he revealed that he self-injects his insulin after the CMA's dial the pen. He continued that he could self-dial the pen if needed by counting the clicks of the pen. He stated that due to his poor vision he likes the CMAs to dial the insulin pen. Interview with Regional Licensed Nurse on 02/08/23 at 02:55 PM, she confirmed R3 electronic record lacked an assessment which confirmed he could safely and accurately self-inject his insulin without staff assistance. The operator failed to ensure the "Licensed Nurse" (LN) performed an assessment determining R3 could safely and accurately self-inject his insulin without staff assistance.	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 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 medications. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (b) The facility reported a census of 12 residents. The sample included 3 "Residents'" (R's 1, 2, and 3) and 4 focused reviews (R's 5, 6, and 7). Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) reflected the self-administration of insulin for R3. Findings included: - Interview with Operator A on 02/06/22 at approximately 04:30 PM during the completion of the departments "Entrance Tour Checklist", she revealed the "Certified Medication Aide's" (CMA'S) dial the insulin pens for the residents, and the residents self-inject the insulin. Record Review on 02/07/23 of the facility	S3186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 provided "Resident Roster" revealed R3 received insulin injections. 02/02/23 Record review for R3 revealed an admission date of 01/17/22, with diagnoses of end stage renal disease, dependence on renal dialysis, history of falling, atherosclerotic heart disease, presence of coronary angioplasty implant and graft, long term use of antithrombotic and anti-platelets, type 2 diabetes, and long-term use of insulin. Record review of R3 "Functional Capacity Screen" (FCS) dated 01/18/22 identified the resident required supervision with bathing. He was independent with dressing, toileting, transferring, walking, and eating. He lacked the ability to manage his own medications, and was marked with falls, impaired vision, and impaired hearing. His cognition was intact, and he was able to make himself understood and he understood others. He used no mobility device. Record review of R3 combined "Negotiated Service Agreement" (NSA)/ "Health Service Plan" (HSP) instructed staff to provide the following health care services: R3 could require stand by assist for bathing, R3 would ask for help if needed. Staff to physical assist with medication administration, and check resident blood sugar prior to meals, at bedtime, and as needed. R3 NSA lacked the reflection of the self-injection of his insulin. Record review of R3 "Electronic Medication Administration Record" revealed the following order:	S3186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 NovoLOG Solution (Insulin Aspart) inject as per sliding scale: If 60-179=0 180-200=1 unit 201-260=2 units 261-330=3 units 331-390=4units 391-450=5units 451-500=6units If blood sugar is greater than 500 call the doctor. Subcutaneously every 4 hours as needed for hyperglycemia related to Type 2 Diabetes Mellitus with Hyperglycemia, supervised self - administration. Give as needed at 0630, 1100, and 1600 prior to meals. Order date 09/26/22. Interview on 02/08/23 at 01:42 PM with R3, he revealed that he self-injects his insulin after the CMA's dial the pen. He continued that he could self-dial the pen if needed by counting the clicks of the pen. He stated that due to his poor vision he likes the CMAs to dial the insulin pen. The operator failed to ensure the "Negotiated Service Agreement" (NSA) reflected the self-administration of insulin for R3.	S3186		
S3215 SS=F	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	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 13 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 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: K.A.R. 26-41-205 (h) (4) The facility reported a census of 12 residents. Based on observation and interview the operator failed to ensure the licensed nurse did not administer the Aplisol 0.1 units/milliliter solution, beyond 30 days from the date the bottle was accessed/opened. Findings included:	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 14 - 02/06/23 at approximately 04:55 PM Observation of the contents of the small black refrigerator in the facility medication room revealed one opened box of Aplisol 0.1 units/milliliter solution, and one sealed box of Aplisol 0.1 units/milliliter solution. The opened vial had been accessed and was half full. The bottle and the box lacked a date the vial was opened. 02/08/23 at 02:55 PM with Regional Licensed Nurse B,. she confirmed the Aplisol 0.1 units/milliliter solution bottle and box lacked the date the bottle was accessed/opened. Record review on 02/08/23 of the Aplisol manufacturers recommendations revealed the following statement: "Aplisol vials should be inspected visually for both particulate matter and discoloration prior to administration and discarded if either is seen. Vials in use for more than 30 days should be discarded". https://www.fda.gov/files/vaccines%2C%20blood%20%26%20biologics/published/Package-Insert--Aplisol.pdf The operator failed to ensure the licensed nurse did not administer the Aplisol 0.1 units/milliliter solution, beyond 30 days from the date the bottle was accessed/opened.	S3215		
S3216 SS=D	26-41-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of	S3216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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
S3216	Continued From page 15 all medications managed by the facility in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (i) (2) The facility reported a census of 12 residents. The sample include 3 "Residents'" (R's 1, 2, and 3) and 4 focused reviews, (R's 4, 5, 6, and 7). Based on observation, interview, and record review, the operator failed to ensure the topical Haloperidol 1 milligram/1 milliliter was destroyed and the medication destruction was documented according to acceptable standards of practice when R7 discharged from the facility. Findings included:	S3216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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
S3216	Continued From page 16 - 02/06/23 at 04:50 PM observation, "Certified Medication Aide" (CMA) D opened the locked medication cart. Observation in the third drawer down on the left side of the drawer was a zip lock bag of seven, three milliliter syringes with an off-white cream like substance in the syringes. The label on the bag identified the substance as Haloperidol 1 milligram/1 milliliter and was prescribed for R7 and the instructions were to be administer 1 milliliter as needed. Interview at the time of the observation with CMA D on the process of administering the as needed medications revealed that R7 had discharged from the facility. Record review on 02/08/23 of R7 "Progress Notes" revealed the following entry: 01/29/23 at 11:49 PM "Nurses Note- Elder passed away at 11:40 PM. Hospice notified and are on their way." Record review on 02/08/23 of the facility policy titled "Medication Donation/Destruction" dated 06/10/2019 revealed the policy lacked a time frame for the destruction of medications after the resident left the facility. The operator failed to ensure the topical Haloperidol 1 milligram/1 milliliter was destroyed and the medication destruction was documented according to acceptable standards of practice when R7 discharged from the facility.	S3216		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 (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: K.A.R. 26-41-105 (f)(11) The facility reported a census of 12 residents. The sample included 3 "Residents'" (R's) (R's 1, 2 and 3) and 4 focused reviews (R's 4, 5, 6, and 7). Based on record review and interview the operator failed to ensure the resident record contained documentation of all incidents, symptom, and other indications of illness or injury which included the date, time of occurrence, action taken and results of the action for R6 when she was found on the floor on 05/16/22 and further lacked documentation of the resident being discharged to another facility. Findings included: - Focused record review on 02/07/23 revealed R6 had an admission date to the facility on 04/18/22 with diagnoses of major depressive disorder, atrophy of thyroid, hypothyroidism, chronic obstructive pulmonary disease, vitamin d deficiency, age related osteoporosis without current pathological fracture. Review of R6 "Functional Capacity Screen" (FCS) revealed the resident required physical assistance with bathing, dressing, and toileting.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 She was unable to walk, she lacked the ability to manage her own medications, she had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. She could sometimes make herself understood and she sometimes understood others. She was marked with impaired vision; impaired decision making and used a wheelchair mobility device. Review of R6 combined "Negotiated Service Agreement" (NSA)/" Health Service Plan" (HSP) instructed staff to provide the following health services: provide physical assist with bathing, dressing, she required nighttime checks, and she could bear weight to transfer. She would require assistance with oxygen needs and the provider of supplies was identified. Record review of R6 electronic "Progress Notes" revealed the following entries: 04/18/22 at 02:00 PM "Resident admitted to facility at 02:00PM via private transportation. Resident was accompanied into facility by husband via wheelchair." 04/20/22 at 08:30 AM "This nurse spoke with resident's primary care provider office about getting orders for physical and occupational therapy." 04/21/22 at 11:15 AM It was reported to the nurse that the resident oxygen level was only reading around 50% from the "Certified Medication Aide" (CMA) on duty. The nurse went to the resident and checked her oxygen level, and it was at 52%, she had no signs of shortness	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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	S3261		

of breath or labored breathing. The nasal canula was found to not be in the nose correctly. The nurse properly positioned the canula and the resident oxygen was reported at 90%. New order use tape to hold the nasal canula in place.

The record lacked a follow up note to see if the tape was effective in holding the nasal canula in place for R6.
04/24/22 at 10:59AM "Staff called the nurse about resident not being very responsive. Staff tried to administer medication; resident was unable to take medication." Resident husband was at the bedside and stated he wanted the resident to go to the local hospital. "Staff called the nurse; nurse said to go ahead and get her checked out. Emergency medical services arrived at 12:15PM and took her to the hospital".

The record lacked a follow up entry on R6 condition after leaving the facility.

05/06/22 at 2:30PM Resident arrived at facility from a skilled nursing facility. The resident is now a two person assist. The nurse spoke to the resident husband regarding obtaining orders from the primary care provider on resident receiving occupational and physical therapy services.

The record lacked a follow up entry on the inquiry with the resident primary care provider for occupational and physical therapy services.

05/16/22 at 04:15AM "This CMA went to check on elder and found elder on floor beside the bed. Vitals taken blood pressure 175/76, pulse 80, respirations 18, temperature 97.6 Fahrenheit,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 20	S3261		

and oxygen level 96%. Called director of nursing"

The record lacked an entry from the nurse on the actions taken and the results of the actions taken regarding the fall on 05/16/22 and R6 safety.

The next entry is dated 05/23/33 at 10:49AM "This nurse went with the CMA on duty to help get the resident out of bed and dressed. This nurse noticed a bruise behind the resident's right knee. The resident has continuing complaint of pain any time her legs are moved. This nurse tried to help the resident stand up so the CMA could pull up her briefs and pants, and the resident was unable to bear any weight. This nurse and the CMA were unable to get the resident up or to her chair. This nurse and the CMA got the resident changed in bed. While changing the resident in bed, the resident was pushing this nurse and the CMA wither hands and yelling. This nurse and the DMA got the resident dressed and adjusted in bed".

05/23/22 at 11:04AM "This nurse spoke with resident's primary care provider. Primary care provider gave this nurse phone order to do mobile x-ray on the resident's right knee."

The record lacked an entry from the nurse addressing R6 pain and discomfort.

05/24/22 at 09:34AM the primary care provider office called: the resident ha a distal displaced femur fracture of the right femur. They were scheduling with orthopedics for an appointment. Resident also had a urinary tract infection and gave orders for Doxycycline 100milligrams two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 21 times daily by mouth for seven days, and for Tylenol 325 milligrams two tablets by mouth 4 times daily for seven days. The record lacked an entry from the facility nurse on the effectiveness of the Doxycycline and Tylenol for R6 pain and symptoms of urinary tract infection. 05/26/22 at 09:42AM "The system has identified a possible drug allergy for the following order: oxyCODONE- Acetaminophen tablet 5milligrams of oxyCODONE and 325milligrams of Acetaminophen give 1 tablet by mouth three times a day for pain. Interview on 02/08/23 at 02:55PM with Operator A, she confirmed R6 was discharged from the facility prior to the healing of the fractured femur, she stated the facility could not meet R6 needs. The record lacked an entry for R6 discharge. The operator failed to ensure the resident record contained documentation of all incidents, symptom, and other indications of illness or injury which included the date, time of occurrence, action taken and results of the action for R6 when she was found on the floor on 05/16/22, and further lacked documentation of the resident being discharged to another facility.	S3261		
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:	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 22 (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-104 (d) (3) The facility reported a census of 12 residents. Based on record review and interview the operator failed to ensure a review of the facility's emergency management plan was reviewed with residents every quarter. Findings included: - 02/07/23 Record review of the facility provided "Resident Council Meeting Minutes" revealed the last quarterly emergency preparedness training with residents was performed on 09/13/2019 and 12/04/2019. 02/07/23 Record review of the facility provided policy titled "Resident Council Meetings" dated 05/10, revealed item number seven stated the	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019010	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON RETIREMENT COMMUNITY	1909 E FOURTH STREET PITTSBURG, KS 66762

(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 23 following: "Kansas to review emergency preparedness quarterly with the residents". Interview 02/08/23 at 02:55 PM with Operator A, she confirmed the resident council records lacked documentation showing quarterly emergency preparedness training with residents. The operator failed to ensure a review of the facility's emergency management plan was reviewed with residents every quarter.	S3280		