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	N044004	A. BUILDING: _____ B. WING _____	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANEW HEALTHCARE ESTATES	415 E WALNUT ST NORTONVILLE, KS 66060

(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 resurvey with a complaint #183111 at the above named Assisted Living conducted on 03/06/24.	S 000		
S3055 SS=F	26-41-101 (l) Survey Report (l) Survey report and plan of correction. Each administrator or operator shall ensure that a copy of the most recent survey report and plan of correction is available in a public area to residents and any other individuals wishing to examine survey results. This REQUIREMENT is not met as evidenced by: 3055 KAR 26-41-101 (l) The facility reported a census of five residents. Based on observation and interview the administrator failed to ensure a copy of the most recent survey report was available in a public area for residents and any other individuals for examination. Findings included: - During the initial tour of the facility on 03/06/24 at approximately 10:30 AM revealed a file holder mounted on the administrator's office door which contained a three-ring binder with state survey results. This binder had a designated tab for the assisted living facility (ALF) results but there were no ALF survey results contained in this binder.	S3055		

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

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S3055	Continued From page 1 On 03/06/24 at approximately 10:30 AM Administrative Staff A confirmed she was not able to locate the most recent ALF survey results. The administrator failed to ensure staff kept the most recent survey results in an area available in a public area for anyone to review.	S3055		
S3085 SS=F	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: 3085 KAR 26-41-202(a)(1) The facility reported a census of five residents with three residents included in the sample.	S3085		

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S3085	Continued From page 2	S3085		

Based on observation, interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed based on the resident's "Functional Capacity Screen" (FCS), service needs, and preferences for resident (R)101, R102 and R103.

Findings included:

- R101's medical record revealed she moved into the facility on 02/21/24.

The 02/20/24 FCS identified R101 was unable to management treatments.

The 02/20/24 NSA did not address what services staff provided for the management of R101's treatments.

On 03/06/24 at 03:45 PM Administrative Nurse B stated R101's NSA did not address management of treatments.

The administrator failed to ensure R101's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences.

- R102's medical record revealed he moved into the facility on 03/08/21.

The 03/02/23 FCS identified R102 required physical assistance with walking/mobility and was unable to manage her treatments.

The 03/02/23 NSA indicated R102 was independent with transfers/mobility and did not

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S3085	Continued From page 3	S3085		

specify what services staff provided for transfers/mobility and did not address what services staff provided for the management of R102's treatments.

On 03/06/24 at 04:12 PM Administrative Nurse B stated she felt the physical assistance with walking/mobility as indicated on R102's FCS was when he used his walker but stated R102 was independent with the use of his wheelchair. Administrative Nurse B stated the NSA did not address what services staff provided for management of treatments.

The administrator failed to ensure R102's NSA was fully developed to include all items that triggered on the FCS, his service needs, and preferences.

- R103's medical record revealed she moved into the facility on 06/14/21.

The 06/07/23 FCS identified R103 was unable to manage her treatments.

The 06/07/23 NSA did not address what services staff provided for the management of R103's treatments.

03/06/24 at 03:36 PM Administrative Nurse B stated the NSA did not address all that triggered on R103's FCS.

The administrator failed to ensure R103's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences.

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S3248	Continued From page 4	S3248		
S3248 SS=F	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, 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: 3248 KAR 26-41-102(d)(1))2) The facility reported a census of five residents. Based on interview and record review, the	S3248		

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S3248	Continued From page 5 administrator failed to ensure both newly hired employees records reviewed included evidence verification of certification with the Kansas Nurse Aide Registry and a criminal background check was completed. Findings included: - Review of employee files conducted on 03/07/24 revealed the following: Certified Medication Aide (CMA) C was hired on 09/08/23. The Kansas Nurse Aide Registry was checked on 09/11/23 two days after she started working. No documentation was provided for a completed criminal background check. CMA D was hired on 11/13/23. No documentation was provided for a Kansas Nurse Aide Registry check completed prior to or the day of hire. On 03/06/24 at 01:22 PM Administrative Staff A stated she expected nurse aide registry checks and criminal background checks be completed prior to the date of hire for newly hired staff. The administrator failed to ensure verifications of the Kansas Nurse Aide Registry and a criminal background check were completed.	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	S3280		

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S3280	Continued From page 6 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: 3280 KAR 26-41-104(d)(3)(4) The facility reported a census of five residents. Based on record review and interview for all residents and all facility employees, the administrator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with employees and residents and failed to ensure an annual evacuation drill was completed. Findings included: - On 03/06/24 review of documentation of the quarterly reviews of the emergency management plan revealed: Quarterly reviews were not completed with	S3280		

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S3280	Continued From page 7 facility staff from August 2022 to the present. Quarterly reviews were not completed with assisted living residents for the fourth quarter of 2022, the first quarter of 2023, the third quarter of 2023 and the fourth quarter of 2024. No documentation was provided for an annual emergency drill that included evacuation of residents to a secure location completed for 2023. On 03/06/24 at 04:27 PM Administrative Staff A stated she expected there to be quarterly reviews of the emergency management plan with staff and residents as well as the completion of an annual evacuation drill. The administrator failed to ensure the completion of quarterly reviews of the emergency management plan with employees and residents and failed to ensure completion of an annual evacuation drill.	S3280		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a	S3298		

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S3298	Continued From page 8	S3298		

manual, wheel-type can opener, shall not be used.
(3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations.

This REQUIREMENT is not met as evidenced by:
3298
KAR 26-41-206(d)

The facility had a census of five residents and all five residents ate food prepared in the same kitchen. Based on record review and interview the administrator failed to ensure food items were served at the proper temperature.

Findings included:

- On 03/06/24 at 05:00 PM review of the "Food Temperature Log" documentation for breakfast, lunch and supper meals revealed the following:

Review of the 01/28/24 - 02/03/24 "Food Temperature Log" revealed lack of food temperature documentation for breakfast and lunch meals on: 01/29/24, 01/30/24, 02/01/24, and 02/02/24.

Review of the 02/04/24 - 02/21/24 "Food Temperature Log" revealed lack of food temperature documentation for breakfast and lunch meals on: 02/06/24 through 02/10/24 and lack of food temperature documentation for

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S3298	Continued From page 9 supper meals on: 02/07/24 - 02/10/24. On 03/07/24 at 01:27 PM Administrative Staff A stated it was her expectation that food temperatures be obtained and documented. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, hot foods must be maintained at an internal temperature of 135 Fahrenheit (F) or higher and cold foods must be maintained at an internal temperature of 41 F or below. The administrator failed to ensure food items were served at the proper temperature.	S3298		
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: 3299 KAR 26-41-206(e) The facility had a census of five residents. All five 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 document temperatures of food items stored in the refrigerator/freezer were at	S3299		

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S3299	Continued From page 10 acceptable temperatures according to food safety guidelines. Findings included: - Observation on 03/06/24 at 05:00 PM revealed documentation of refrigerator/freezer temperatures documented by staff contained missing documentation as follows: Review of the unlabeled February 2024 "Cooler/Freezer Temperature Chart" #1 revealed the following missing temperature inputs: 02/07/24- PM 02/08/24- PM 02/09/24- PM 02/15/24- PM 02/16/24- AM/PM 02/19/24- AM 02/20/24- AM 02/21/24- PM 02/22/24- AM/PM 02/23/24- AM/PM 02/24/24- AM/PM 02/25/24- AM/PM 02/26/24- PM 02/27/24- PM 02/28/24- PM 02/29/24- AM/PM Review of the unlabeled February 2024 "Cooler/Freezer Temperature Chart" #2 revealed the following missing temperature inputs: 02/19/24- AM 02/20/24- AM 02/21/24- PM 02/22/24- AM/PM	S3299		

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S3299	Continued From page 11 02/23/24- AM/PM 02/26/24- PM 02/27/24- AM/PM 02/28/24- AM/PM 02/29/24- AM/PM Review of the unlabeled February 2024 "Cooler/Freezer Temperature Chart" #3 revealed the following missing temperature inputs: 02/19/24- AM 02/20/24- AM 02/21/24- PM 02/22/24- AM/PM 02/23/24- AM/PM 02/26/24- PM 02/27/24- AM/PM 02/28/24- AM/PM 02/29/24- AM/PM On 03/07/24 at 01:27 PM Administrative Staff A stated it was her expectation that refrigerator and freezer temperatures be taken and documented. The Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, p. 19 documented, "Proper holding temperatures must be maintained during display, storage and transportation. Cold foods must be maintained at an internal temperature of 41F or below." The operator failed to ensure food items were stored under safe and sanitary conditions.	S3299		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe,	S3305		

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S3305	Continued From page 12 sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (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 (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: 3305 KAR 26-41-207(b)(4)	S3305		

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S3305	Continued From page 13 The facility had a census of five residents. All five residents ate food prepared in the same kitchen. The operator failed to ensure sanitary conditions for food service by not ensuring designated staff documented dishwasher chemical strength at least daily. Findings included: Review of the February 2024 "Dish Machine Temperature/Chemical Log" revealed missing documentation for the following: 02/10/24 Breakfast, Noon Meal, and Evening Meal 02/11/24 Breakfast, Noon Meal, and Evening Meal 02/16/24 Noon Meal, and Evening Meal 02/17/24 - 02/29/24 Breakfast, Noon Meal, and Evening Meal. On 03/07/24 at 01:21 PM Administrative Staff A stated it was her expectation that sanitization levels for the dishwasher be documented. The August 2017 "Focus on Food Safety" published by the Kansas Department of Agriculture page 23 under the heading of "Cleaning and Sanitizing" documented, "Chemicals must be auto-dispensed into final rinse water; check at least daily." The administrator failed to ensure sanitary conditions in the kitchen by failing to ensure documentation of the dish washer chemical strength was logged at least daily.	S3305		

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S3310	Continued From page 14	S3310		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: 3310 KAR 26-41-207(c) The facility reported a census of five residents. Based on record review and interview the administrator failed to ensure the facility was in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 . Findings include: - Review of two newly hired staff records revealed the following: Certified Medication Aide (CMA) C was hired on	S3310		

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S3310	Continued From page 15 09/08/23 did not have a TB Symptom Screening Questionnaire or a two-step TB skin test (TST) completed upon hire. On 03/06/24 at 01:22 PM Administrative Staff A stated a TB questionnaire and a two-step TST should be started by the day staff started work. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new ...employee shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within 7 days of ...employment ...Each new ...employee shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of ...employment ..." The administrator failed to ensure the compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. - Resident (R)101 admitted to the facility on 02/21/24. Review of medical records revealed R101 did not have a TB Symptom Screen Questionnaire or a two-step TST completed upon admission to the facility. On 03/06/24 at 03:45 PM Administrative Nurse B stated a TB Symptom Screen Questionnaire nor a two-step TST were completed for R101. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall have an initial TB symptom	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N044004	A. BUILDING: _____ B. WING _____	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3310	Continued From page 16 screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within 7 days of residency ...Each new resident ...shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of residency ..." - R102 admitted to the facility on 03/08/21. Review of medical records revealed R102 did not have a TB Symptom Screening Questionnaire completed annually in 2023. On 03/06/24 at 02:04 PM Administrative Staff A stated she could not find an annual TB Symptom Screen Questionnaire completed for R102 in 2023. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each resident ...shall have an annual TB symptom screen ..." The administrator failed to ensure the compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. - R103 admitted to the facility on 06/14/21. Review of medical records revealed R103 did not have a TB Symptom Screening Questionnaire completed annually in 2023. On 03/06/24 at 02:04 PM Administrative Staff A stated she could not find an annual TB Symptom Screen Questionnaire completed for R103 in 2023.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N044004	A. BUILDING: _____ B. WING _____	03/06/2024

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S3310	Continued From page 17 The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each resident ...shall have an annual TB symptom screen ..." The administrator failed to ensure the compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		
S3335 SS=F	28-39-254 BUILDING EXTERIOR (f) General building exterior. (1) Each exterior pathway or access to the facility's common use areas and entrance or exit ways shall be: (A) made of hard smooth material; (B) barrier free; and (C) maintained in good repair. (2) There shall be a means of monitoring each exterior entry and exit for security purposes. (3) Outdoor recreation areas shall be provided and available to residents. This REQUIREMENT is not met as evidenced by: 3335 KAR 28-39-254(f)(1)(C) The facility reported a census of five residents. Based on observation, and interview the administrator failed to ensure each exterior	S3335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N044004	A. BUILDING: _____ B. WING _____	03/06/2024

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S3335	Continued From page 18	S3335		

pathway was maintained in good repair.

Findings included:

- Observations on 03/09/24 revealed the following cracks to the concrete sidewalks leading to the assisted living duplexes:
Sidewalk crack #1 was approximately 31 inches long and approximately three and one-half inches wide at its widest point.

Sidewalk crack #2/4 consisted of two large cracks. One had a triangular shape that measured approximately 12 inches by 12 inches. The other crack measured approximately 41 inches long and 12 inches wide at its widest point.

Sidewalk crack #3 measured approximately 36 inches long by five inches at its widest point.

Sidewalk crack #5 measured approximately 34 inches long and approximately four inches at its widest point.

Sidewalk crack #6 measured approximately 30 inches long and approximately four inches at its widest point.

On 03/06/24 at 03:41 PM resident (R)102 stated the cracks in the sidewalks have existed for a long time and that he has gotten his wheelchair stuck in the cracks several times.

The administrator failed to ensure sidewalks were maintained in good repair.