STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(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 complaint investigation 101104 at the above residential health care facility conducted on 8-30-16, 8-31-16, 9-1-16 and 9-6-16.	S 000		
S 110 SS=D	26-39-103 (c) NOTICE OF RIGHTS AND SERVICES (c) Notice of rights and services. (1) Before admission, the administrator or operator shall ensure that each resident or the resident's legal representative is informed, both orally and in writing, of the following in a language the resident or the resident ' s legal representative understands: (A) The rights of the resident; (B) the rules governing resident conduct and responsibility; (C) the current rate for the level of care and services to be provided; and (D) if applicable, any additional fees that will be charged for optional services. (2) The administrator or operator shall ensure that each resident or the resident ' s legal representative is notified in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care. This STANDARD is not met as evidenced by: KAR 26-39-103(c)(1)(A)(B) The facility reported a census of 16 residents. The sample included 3 residents. Based on record review and interview for 1 (#830) of 3	S 110		

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
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(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 110	Continued From page 1 sampled residents, the operator failed to ensure that each resident or the resident's legal representative is informed, both orally and in writing in a language the resident or the resident's legal representative understands of the rights of the resident and the rules governing resident conduct and responsibility. Findings included: - Record review for resident #830 revealed admission on 5-30-16. The admission "Contract" stated "Resident agrees to abide by all facility rules..." The record lacked documentation of the receipt of the rights of the resident and rules governing resident conduct and responsibility. Interview on 8-31-16 at 3:11 p.m. with administrative staff A and operator confirmed the record lacked documentation that the resident or the resident's legal representative had received both orally and in writing a copy of the resident's rights and rules governing resident conduct and responsibility. Operator stated he/she did not have a facility handbook or other document outlining rules governing resident conduct and responsibility and no resident had been given such. For resident #830, the operator failed to ensure that the resident or the resident's legal representative was informed, both orally and in writing of the rights of the resident and the rules governing resident conduct and responsibility.	S 110		
S 230 SS=D	26-39-102 (b) (c) Admission Advanced Directives Resident Rights b) At the time of admission, adult care home staff	S 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(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 230	Continued From page 2 shall inform the resident or the resident ' s legal representative, in writing, of the state statutes related to advance medical directives. (1) If a resident has an advance medical directive currently in effect, the facility shall keep a copy on file in the resident ' s clinical record. (2) The administrator or operator, or the designee, shall ensure the development and implementation of policies and procedures related to advance medical directives. (c) The administrator or operator, or the designee, shall provide a copy of resident rights, the adult care home's policies and procedures for advance medical directives, and the adult care home's grievance policy to each resident or the resident's legal representative before the prospective resident signs any admission agreement. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(b) The facility reported a census of 16 residents. The sample included 3 residents. Based on record review and interview for 1 (#830) of 3 sampled residents, the operator failed to ensure adult care home staff informed the resident or the resident's legal representative in writing of the state statutes related to advance medical directives. Findings included: - Review of record for resident #830 revealed admission on 5-30-16 with diagnoses of Memory Loss, Diabetes Mellitus, Hypertension and Hyperlipidemia.	S 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(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 230	Continued From page 3 The record lacked documentation that resident was informed of the right to formulate advance directives, documentation of whether resident formulated any advanced directives and a copy of any advanced directives. Interview on 8-31-16 at 11:24 a.m. with administrative staff A and operator, confirmed the record lacked documentation that resident was informed of the right to formulate advance directives or documentation or whether resident had formulated any type of advance directive. Administrative staff A confirmed the facility did have this form, but was unable to locate the signed acknowledgement for receipt of information regarding the right to formulate an advance directive. For resident #830, the operator failed to ensure adult care home staff informed the resident or the resident's legal representative in writing of the state statutes related to advance medical directives.	S 230		
S3101 SS=F	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h)	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(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
S3101	Continued From page 4	S3101		

The facility reported a census of 16 residents. The sample included 3 residents. For all residents, the operator failed to ensure each individual involved in the development of the negotiated service agreement (NSA) signed the agreement as evidenced by record review and interview, for 3 (#830, #831, and #832) of 3 sampled residents.

Findings included:

- Record review for resident #830 revealed admission on 5-30-16 with diagnoses Memory Loss, Diabetes Mellitus, Hypertension and Hyperlipidemia. The Functional Capacity Screen (FCS) dated 5-30-16 recorded resident required health care services.

The negotiated service agreement (NSA) dated 5-30-16 was signed by the operator and resident's legal representative. The NSA lacked signature of the licensed nurse.

Interview on 8-31-16 at 12:38 p.m. with administrative staff A and operator confirmed the NSA lacked the signature of the licensed nurse who participated in the development of the NSA. Stated the form lacked a line for the nurse's signature and the licensed nurse had not signed any of the agreements.

For resident #830, the operator failed to ensure each individual involved in the development of the NSA signed the agreement.

- Record review for resident #831 revealed admission on 3-21-12 with diagnoses Atrial Fibrillation, Anxiety, Depression, Hypertension, Hyperlipidemia and Hypothyroidism. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(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
S3101	Continued From page 5 Functional Capacity Screen (FCS) dated 3-28-16 recorded resident required health care services. The negotiated service agreement (NSA/HCSP) dated 3-28-16 was signed by the operator only. The NSA/HCSP lacked signature of the licensed nurse and resident or the resident's legal representative. Interview on 8-31-16 at 2:12 p.m. with administrative staff A and operator confirmed the NSA lacked the signature of the licensed nurse and the resident or the resident's legal representative. Stated the form lacked a line for the nurse's signature and the licensed nurse had not signed any of the agreements. For resident #831, the operator failed to ensure each individual involved in the development of the NSA signed the agreement. - Record review for resident #832 revealed admission on 3-1-12 with diagnoses Anxiety, Bipolar Mood Disorder, Coronary Artery Disease, Depression, Chronic Obstructive Pulmonary Disease, Hypertension, Hyperlipidemia, Insomnia, Pain and Peripheral Neuropathy. The Functional Capacity Screen (FCS) dated 3-28-15 recorded resident required health care services. The negotiated service agreement (NSA) dated 3-28-15 was signed by the operator and resident's legal representative. The NSA lacked signature of the licensed nurse. Interview on 8-31-16 at 12:38 p.m. with administrative staff A and operator confirmed the	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(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
S3101	Continued From page 6 NSA lacked the signature of the licensed nurse who participated in the development of the NSA. Stated the form lacked a line for the nurse's signature and the licensed nurse had not signed any of the agreements. For resident #832, the operator failed to ensure each individual involved in the development of the NSA signed the agreement.	S3101		
S3166 SS=E	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(e) The facility reported a census of 16 residents. The sample included 3 residents. Based on record review and interview for 1 (#830) of 1 sampled residents receiving blood glucose monitoring; and 2 (certified staff E, G) of 2 certified medication aides performing blood glucose monitoring, a nursing procedure not included in the medication aide curriculum, the operator failed to ensure a licensed nurse delegated the procedure to certified medication aides (CMAs) under the Kansas Nurse Practice Act, K.S.A. 65-1124 and amendments thereto.	S3166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(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 7 Findings included: - Record review for resident #830 revealed admission on 5-30-16 with diagnoses Diabetes Mellitus, Hypertension, Hyperlipidemia, and Memory Loss. The functional capacity screen dated 5-30-16 recorded resident unable to perform management of medications and treatments. The negotiated service agreement/health care service plan (NSA/HCSP) dated 5-31-16 stated medications will be administered by certified staff. (The NSA/HCSP lacked documentation of who is responsible for blood glucose monitoring.) Review of resident's Medication Administration Record (MAR) for August 2016 revealed documentation of blood glucose readings recorded by certified medication aides (CMAs). - Personnel record review for 2 CMAs on 8-30-16 at 3:30 p.m. with operator and administrative staff A, revealed the following: Certified staff E, with date of hire 3-1-15: the record lacked documentation of delegation of blood glucose monitoring. Certified staff G, with date of hire 4-28-15: the record lacked documentation for delegation blood glucose monitoring. The facility lacked a policy for Delegation of Nursing Procedures. Interview on 8-30-16 at 3:30 p.m. with administrative staff A during review of personnel records confirmed the staff records lacked documentation of competency checklists for each CMA performing blood glucose monitoring.	S3166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(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 Interview on 8-31-16 at 11:35 a.m. with licensed staff B identified 3 residents who were receiving blood glucose monitoring and confirmed CMAs performed the procedure. Licensed staff B confirmed he/she had not performed competency checks for the CMAs. The licensed nurse failed to appropriately delegate nursing procedures/tasks to CMAs under the Kansas Nurse Practice Act K.S.A. 65-1124 related to the performance of blood glucose monitoring with the use of glucometers for resident #830 and all residents receiving blood glucose monitoring.	S3166		
S3235 SS=F	26-41-103 (b) Staff Development Topics (b) The topics for orientation and in-service education shall include the following: (1) Principles of assisted living; (2) fire prevention and safety; (3) disaster procedures; (4) accident prevention; (5) resident rights; (6) infection control; and (7) prevention of abuse, neglect, and exploitation of residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-103(b)(1)(2)(3)(4)(5)(6)(7) The facility reported a census of 16 residents. The sample included 3 residents. Based on record review and interview for all staff, the operator failed to ensure regular in-service	S3235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(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
S3235	Continued From page 9	S3235		

education for all employees which included the following topics: 1) Principles of assisted living; 2) fire prevention and safety; 3) disaster procedures; 4) accident prevention; 5) resident rights; 6) infection control; and 7) prevention of abuse, neglect, and exploitation of residents.

Findings included:

- Review of in-service records on 8-31-16 at 1:30 p.m. with administrative staff A revealed the records lacked documentation of review of annual in-service requirements.

Facility policy titled "Staff Development Policy" stated:
"It is the policy...that the administrator or operator shall ensure the provision of orientation to new employees and regular in-service education for all employees to ensure that the services provided assist residents to attain and maintain their individuality, autonomy, dignity, independence and ability to make choices in a home environment. The topics of orientation and in-service education shall include the following: Principles of assisted living, fire prevention and safety, disaster procedures, resident's rights, infection control and prevention of abuse, neglect and exploitation..."

Interview on 8-31-16 at 1:38 a.m. with administrative staff A confirmed the in-services had not been done and the facility lacked documentation of completion of annual in-service topics. Confirmed the facility had not followed it's policy.

For all employees, the operator failed to ensure regular in-service education to include topics: principles of assisted living, fire prevention and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(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
S3235	Continued From page 10 safety, disaster procedures, resident's rights, infection control and prevention of abuse, neglect and exploitation	S3235		
S3248 SS=E	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3248	Continued From page 11 The facility reported a census of 16 residents. The sample included 3 residents. The facility identified 10 employees hired since last resurvey, with 4 certified staff, and 1 licensed staff reviewed. Based on record review and interview for 4 (certified staff D, E, F, G) of 4 certified staff reviewed, the operator failed to ensure the employee records contained documentation of evidence of certification for each employee performing a function that required specialized education or training; supporting documentation for criminal background checks pursuant to K.S.A. 39-970 and amendments thereto; and 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. Findings included: - Certified staff D (date of hire 6-15-16): the record lacked documentation of certification, documentation of a criminal background check, and supporting documentation from the Kansas nurse aide registry that the employee does not have a finding of having abused, neglected or exploited a resident in an adult care home. - Certified staff E (date of hire 3-1-15): The record contained a registry check performed on 10-14-15. The record lacked documentation that the registry was checked on or before date of hire. Further lacked documentation of a criminal background check and documentation of current certification as a nurse aide. - Certified staff F (date of hire 12-15-14): The record contained a registry check performed on 10-14-15. The record lacked documentation that the registry was checked on or before date of	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3248	Continued From page 12 hire. The record lacked documentation of a criminal background check and documentation of current certification. Per Kansas Nurse Aide Registry, the certification expired 2-25-16. - Certified staff G (date of hire 4-28-15): The record contained a registry check performed on 10-14-15. The record lacked documentation that the registry was checked on or before date of hire. the record lacked documentation of a criminal background check and documentation of current certifications for medication aide and nurse aide. Interview on 8-30-16 at 3:30 p.m. with operator and administrative staff A confirmed had not followed proper procedure for contacting the registry and requesting criminal background checks. Further confirmed there was no system in place for ongoing monitoring of employee records to ensure certifications were kept current. For certified staff D, E, F, G, the operator failed to ensure the employee records contained documentation of evidence of certification for each employee performing a function that required specialized education or training; supporting documentation for criminal background checks pursuant to K.S.A. 39-970 and amendments thereto; and 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.	S3248		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(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 13 disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 16 residents. The sample included 3 residents. Based on record review and interview for all residents and all facility employees, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with employees and residents. Findings included: - Review of the facility emergency management plan on 8-31-16 at 1:30 p.m. with administrative staff A and operator revealed review with staff only on 8-29-14 (fire, evacuation, tornado and loss of power) and 7-1-16. The facility lacked documentation of quarterly	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(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 14 reviews of the Emergency Management Plan for the remainder of 2014, all of 2015 and consistent quarterly review for 2016 for all staff and residents. Facility "Emergency Management Policy" stated: "It is the policy of (facility) to provide a quarterly review of the facility's emergency management plan with employees and residents..." Observation on 8-30-16 at 1:20 p.m. during tour of facility revealed framed notices for what to do in case of Fire or Tornado; and evacuation routes posted throughout building. Interview on 8-31-16 at 1:38 p.m. with administrative staff A and operator, confirmed the record lacked documentation of quarterly review of the emergency management plan with staff and residents. Operator stated he/she goes to each residents room monthly to review the plan, but confirmed he/she failed to document this and failed to follow facility policy. For all employees and residents, the operator failed to ensure emergency preparedness by ensuring the emergency management plan was reviewed quarterly.	S3280		
S3310 SS=E	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	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3310	Continued From page 15 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: KAR 26-41-207(c) The facility reported a census of 16 residents. The sample included 3 residents. Based on record reviews and interviews, for 1 of 3 sampled residents (#830), and for 5 of 5 employee records reviewed, the operator failed to ensure the facility's compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Review of employee records revealed: Licensed staff B hired on 8-23-16: record contained TB skin test performed on 7-20-16 from a previous employer. The record lacked documentation of a second TB test and symptom screening. Certified staff D: record contained TB skin test performed on 8-19-16. The record lacked documentation of TB testing performed within 7 days of date of hire (6-15-16). The record lacked further documentation of a second step and symptom screening. Certified staff E: record contained documentation of TB skin test performed by another employer on 7-30-15. The record lacked documentation of a	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061007	A. BUILDING: _____ B. WING _____	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB ESTATES LP	2 LEWIS DRIVE PAOLA, KS 66071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3310	Continued From page 16 2-step TB skin test initiated within 7 days of date of hire (3-1-15) and a symptom screening. Certified staff F: record contained documentation of a TB skin test performed on 7-11-16. The record lacked documentation of a 2- step TB skin test initiated within 7 days of date of hire (12-15-14) and a symptom screening. Certified staff G: record contained documentation of TB skin test performed on 11-13-15. The record lacked documentation of a 2-step TB skin test initiated within 7 days of date of hire (4-28-15) and a symptom screening. Interview on 8-30-16 at 3:30 p.m. with administrative staff A confirmed the employee records lacked documentation of TB testing in accordance with the department's tuberculosis guidelines. - Record review for resident #830 revealed admission on 5-30-16. The record contained documentation of a TB skin test performed on 6-1-16. The record lacked documentation of a second step or screening as required by the department's TB guidelines. Interview on 8-31-16 at 3:11 p.m. with administrative staff A confirmed the record lacked documentation of a symptom screening and a second step. For resident #830 and 5 of 5 employee records, the operator failed to ensure the facility's compliance with the department's tuberculosis guidelines.	S3310		