STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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 #183834 at the above named Assisted Living on 04/10/24 and 04/11/24.	S 000		
S 110 SS=E	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: 0110 KAR 26-39-103(c)(1)(B) The facility reported a census of 23 residents. Based on interview and record review the	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
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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 operator failed to ensure resident (R)102, R103 and R105 were informed, both orally and in writing of the rules governing resident conduct and responsibility. Findings included: - R102 was admitted to the facility on 10/01/22. Review of R102's medical records failed to locate documentation that he was informed of the rules governing resident conduct and responsibility. On 04/11/24 at 12:50 PM Administrative Nurse A stated she was not able to locate any information concerning resident's responsibilities and code of conduct was provided to R102. The operator failed to ensure R102 was informed both orally and in writing of the rules governing resident conduct and responsibility. - R103 was admitted to the facility on 07/17/14. Review of R103's medical records failed to locate documentation that she was informed of the rules governing resident conduct and responsibility. On 04/11/24 at 01:08 PM Administrative Nurse A stated she was not able to locate any information concerning resident's responsibilities and code of conduct was provided to R103. The operator failed to ensure R103 was informed both orally and in writing of the rules governing resident conduct and responsibility.	S 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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 2 - R105 was admitted to the facility on 12/18/21. Review of R105's medical records failed to locate documentation that she was informed of the rules governing resident conduct and responsibility. On 04/11/24 at 12:37 PM Administrative Nurse A stated she was not able to locate any information concerning resident's responsibilities and code of conduct was provided to R105. The operator failed to ensure R105 was informed both orally and in writing of the rules governing resident conduct and responsibility.	S 110		
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.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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 This REQUIREMENT is not met as evidenced by: 3085 KAR 26-41-202(a)(1) The facility reported a census of 23 residents with three residents included in the sample. 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)105. Findings included: - R105's medical record revealed she moved into the facility on 12/18/21. The 07/20/23 FCS identified R105 was independent with transfers. The 07/20/23 NSA did not identify that R105 used a transfer pole for transfers in and out of bed. On 04/11/24 at 11:32 AM R105 was alert and oriented. There was a transfer pole installed next to her bed. On 04/11/24 at 11:32 AM R105 stated she was independent with transfers and used a transfer pole which she has had for about a year. On 04/11/24 at 12:37 PM Administrative Nurse A stated she expected R105's NSA to include the use of a transfer pole.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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 The operator failed to ensure R105's NSA was fully developed to include all items that triggered on the FCS, his service needs, and preferences.	S3085		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: 3092 KAR 26-41-202(d)(4) The facility reported a census of 23 residents. The sample included three residents. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for resident (R)103 was revised when she started receiving services from hospice. Findings included:	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3092	Continued From page 5 - R103's medical record revealed she moved into the facility on 07/17/14 with a diagnosis of Alzheimer's Disease. Review of R103's medical records failed to include an addendum to her NSA that identified R103 received hospice services. The 02/20/24 "Nursing Progress Note" documented, R103 started on hospice services with a local hospice. On 04/11/24 at 11:15 AM "Certified Medication Aide" (CMA) C stated R103 recently started on hospice services. On 04/11/24 at 01:08 PM Administrative Nurse A stated R103 was on hospice but R103's NSA was not revised to reflect this. The operator failed to ensure R103's NSA was revised to include she received hospice services.	S3092		
S3156 SS=D	26-41-204 (b) Health Care Services (b) If the functional capacity screening indicates that a resident is in need of health care services, a licensed nurse, in collaboration with the resident, the resident ' s legal representative, the case manager, and, if agreed to by the resident or resident ' s legal representative, the resident ' s family, shall develop a health care service plan to be included as part of the negotiated service agreement.	S3156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3156	Continued From page 6	S3156		

This REQUIREMENT is not met as evidenced by:
3156
KAR 26-41-204(b)

The facility reported a census of 23 residents. The sample included three residents. Based on record review and interview, the operator failed to ensure the "Negotiated Service Agreement" (NSA) contained a description of the health care services to be provided for resident (R)103.

Findings included:

-R103's medical record documented she moved into the facility on 07/17/14 with a diagnosis of Alzheimer's Disease.

R103's "Functional Capacity Screen" (FCS) dated 05/16/23 revealed she required staff assistance with bathing, toileting and dressing and staff administered her medications and treatments.

Review of R103's medical records failed to locate a "Health Care Service Plan" (HCSP). R103's medical records revealed she received hospice services.

On 04/11/24 at 11:15 AM "Certified Medication Aide" (CMA) C stated R103 recently started receiving hospice services.

On 04/11/24 at 01:08 PM Administrative Nurse A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3156	Continued From page 7 stated she was unable to find a care plan for R103. The facility failed to develop a HCSP to be included in the NSA for R103.	S3156		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: 3165 KAR 26-41-204(d) The facility reported a census of 23 residents with three residents included in the sample. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) identified the licensed nurse responsible for the implementation and supervision of the health care services plan for resident (R)102, R103 and R105. Findings included: - R102's medical record revealed he moved into the facility on 10/01/22. R102's most recent NSA was completed on 05/15/23. The nurse identified as the nurse	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3165	Continued From page 8	S3165		

responsible for the implementation and supervision of the Health Care Service Plan (HCSP) was no longer employed at the facility and no addendum had been completed to identify the new nurse who was responsible for the implementation and supervision of the HCSP.

On 04/11/24 at 12:50 PM Administrative Nurse A stated an addendum to the NSA was not completed to identify the new nurse responsible for the supervision of the HCSP.

The operator failed to ensure R102's NSA was updated to identify the current licensed nurse responsible for the implementation and supervision of the health care services plan.

- R103's medical record revealed she moved into the facility on 07/17/14.

R103's most recent NSA was completed on 05/15/23. The nurse identified as the nurse responsible for the implementation and supervision of the HCSP was no longer employed at the facility and no addendum had been completed to identify the new nurse who was responsible for the implementation and supervision of the HCSP.

On 04/11/24 at 01:08 PM Administrative Nurse A stated an addendum to the NSA was not completed to identify the new nurse responsible for the supervision of the HCSP.

The operator failed to ensure R103's NSA was updated to identify the current licensed nurse responsible for the implementation and supervision of the health care services plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3165	Continued From page 9 - R105's medical record revealed the resident moved into the facility on 12/18/21. R105's most recent NSA was completed on 07/20/23. The nurse identified as the nurse responsible for the implementation and supervision of the HCSP was no longer employed at the facility and no addendum had been completed to identify the new nurse who was responsible for the implementation and supervision of the HCSP. On 04/11/24 at 12:37 PM Administrative Nurse A stated an addendum to the NSA was not completed to identify the new nurse responsible for the supervision of the HCSP. The operator failed to ensure R105's NSA was updated to identify the current licensed nurse responsible for the implementation and supervision of the health care services plan.	S3165		
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.	S3186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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 10 This REQUIREMENT is not met as evidenced by: 3186 KAR 26-41-205(b) The facility reported a census of 23 residents. The sample included three residents. Based on observation, interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for resident (R)102 identified the responsible person for administration and management of selected medications. Findings included: -R102's medical record revealed he moved into the facility on 10/01/22 with a diagnosis of chronic obstructive pulmonary disease (COPD). The 05/16/23 FCS documented R102 was unable to manage his own medications. The 05/15/23 NSA did not identify that R102 self-administered his inhaler. An order dated 08/24/23 for Ventolin HFA Aerosol Solution 108 micrograms, two puffs inhale orally every four hours as needed for COPD. On 04/10/24 at 11:48 AM R102 was alert and oriented and kept an inhaler in his pocket. On 04/11/24 at 11:48 AM R102 stated he had an inhaler which he self-administered.	S3186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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 On 04/11/24 at 11:12 AM "Certified Medication Aide" (CMA) C stated staff administered R102's medications with exception to his inhaler and does his breathing treatment after staff brought the medication and set up the treatment. On 04/11/24 at 12:50 PM Administrative Nurse A stated R102 used an inhaler that he self-administered and this should have been included in the NSA. The operator failed to ensure the NSA identified who was responsible for administration and management of R102's inhaler.	S3186		
S3225 SS=E	26-41-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the facility and each time the resident experiences any significant change in condition. This REQUIREMENT is not met as evidenced by: 3225	S3225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3225	Continued From page 12 KAR 26-41-205(l) The facility had a census of 23 residents. Three residents were included in the sample. Based on record review and interview the operator failed to ensure a quarterly medication regimen review was completed by a licensed pharmacist for two residents the facility administered medications to. Findings included: - Resident (R)102 was admitted to the facility on 10/01/22. The 05/16/23 "Functional Capacity Screen" (FCS) revealed R102 was unable to manage his own medications. The 05/15/23 "Negotiated Service Agreement" (NSA) documented staff managed and administered R102's medications. Review of R102's medical records failed to locate pharmacy reviews of medications for the first and second quarters of 2023. On 04/11/24 at 12:50 PM Administrative Nurse A stated she was not able to find a medication regimen review for R102 for the first and second quarters of 2023. The operator failed to ensure quarterly medication regimen reviews were offered to R102 on a quarterly basis. - R103 was admitted to the facility on 07/17/14. The 05/16/23 FCS revealed R103 was unable to	S3225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3225	Continued From page 13 manage her own medications. The 05/15/23 NSA documented staff managed and administered R103's medications. Review of R103's medical records failed to locate pharmacy reviews of medications for the first and second quarters of 2023. On 04/11/24 at 01:08 PM Administrative Nurse A stated she was not able to find a medication regimen review for R103 for the first and second quarter of 2023. The operator failed to ensure quarterly medication regimen reviews were offered to R103 on a quarterly basis.	S3225		
S3229 SS=D	26-41-205 (l) (4) Medication Regimen Review Self Administration (l) (4) The administrator or operator, or the designee, shall offer each resident who self-administers medication a medication regimen review to be conducted by a licensed pharmacist at least quarterly and each time a resident experiences a significant change in condition. A licensed nurse shall document the resident ' s decision in the resident ' s clinical record. This REQUIREMENT is not met as evidenced by: 3229 KAR 26-41-205(l)(4) The facility had a census of 23 residents. Three	S3229		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3229	Continued From page 14 residents were included in the sample. Based on record review and interview the operator failed to offer a medication regimen review by a licensed pharmacist at least quarterly for one resident reviewed who self-administered medications. Findings included: - Resident (R)105 was admitted to the facility on 12/18/21. The 07/20/23 "Functional Capacity Screen" (FCS) revealed R105 managed her medications independently. The 07/20/23 "Negotiated Service Agreement" (NSA) documented R105 administered her medications independently. Review of R105's medical records failed to locate a pharmacy review of medications for the first and second quarter of 2023. On 04/11/24 at 11:32 AM R105 stated she administered her own medications. On 04/11/24 at 12:37 PM Administrative Nurse A stated she was not able to find a medication regimen review for R105 for the first and second quarters of 2023. The operator failed to ensure a quarterly medication regimen review was offered to R105 on a quarterly basis.	S3229		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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 15 (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)(4) The facility reported a census of 62 residents. Based on interview and record review, the operator failed to ensure four of five newly hired employees records included evidence of timely	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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 16 verification of licensure or certification was completed prior to or on the date of hire. Findings included: - Review of employee files conducted on 04/10/24 revealed the following: "Certified Medication Aide" (CMA) C was hired on 01/01/23. Documentation provided revealed the Kansas Nurse Aide Registry was not checked until 02/08/24. "Certified Nurse Aide" (CNA) E was hired on 12/18/23. Documentation provided revealed the Kansas Nurse Aide Registry was not checked until 12/26/23. "Licensed Nurse" (LPN) A was hired on 01/15/24. Documentation provided revealed nurse licensure verification was not checked until 04/10/24. CMA G was hired on 11/18/23. Documentation provided revealed the Kansas Nurse Aide Registry was not checked until 02/29/24. The operator failed to ensure timely verifications of staff licensure and certification were completed prior to or on the date of hire.	S3248		
S3260 SS=E	26-41-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any	S3260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3260	Continued From page 17 amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and This REQUIREMENT is not met as evidenced by: 3260 KAR 26-41-105(f)(3) The facility reported a census of 23 residents. The sample included three residents. Based on interview and record review the operator failed to ensure two of three sampled resident (R) records (R102, R103) contained documentation of the admission agreement. Findings included:	S3260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3260	Continued From page 18 -R102's medical record revealed he moved into the facility on 10/01/22. Review of R102's medical record revealed that it lacked documentation of an admission agreement completed upon admission to the assisted living facility. On 04/11/24 at 12:50 PM Administrative Nurse A stated she was not able to find an admission agreement on file for R102. The operator failed to ensure designated staff completed an admission agreement with R102 upon admission to the assisted living facility. -R103's medical record revealed she moved into the facility on 07/17/14. Review of R103's medical record revealed that it lacked documentation of an admission agreement completed upon admission to the assisted living facility. On 04/11/24 at 01:08 PM Administrative Nurse A stated she was not able to find an admission agreement on file for R103. The operator failed to ensure designated staff completed an admission agreement with R103 upon admission to the assisted living facility.	S3260		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms,	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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 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: 3261 KAR 26-41-105(f)(11) The facility reported a census of 23 residents. The sample included three residents. Based on interview and record review the operator failed to ensure resident (R)103's medical record contained documentation of all incidents, symptoms, and other indications of illness or injury. Findings included: -R103's medical record revealed she moved into the facility on 07/17/14 with diagnoses of Alzheimer's Disease. The 05/16/23 "Functional Capacity Screen" (FCS) identified R103 was independent with transfers and ambulation and did not trigger for falls, unsteadiness. The 11/02/23 complaint "Intake Information" form the complainant alleged that on 09/23/23 there was a dance at the senior building and R103 had a fall while dancing with staff. Review of R103's medical record and progress	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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 notes lacked a nursing note and fall investigation for a fall that occurred on 09/23/23. The 10/14/23 "Encounter and Procedures Note" by Nurse Practitioner H documented, "Patient fell several weeks ago at the facility dance onto her buttocks. Staff notes since this event the patient has been complaining of back pain." On 04/11/24 at 01:08 PM Administrative Nurse A stated there should have been documentation in R103's medical records of a fall that occurred during a dance in September of 2023. The operator failed to ensure designated staff included documentation of all incidents, symptoms and other indications of illness or injury including the dated, time of occurrence, action taken, and results of the action.	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: (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	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3280	Continued From page 21 secure location. This REQUIREMENT is not met as evidenced by: 3280 KAR 26-41-104(d)(3) The facility reported a census of 23 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: - On 04/10/24 documentation of quarterly reviews of the " Emergency Management Plan" revealed a lack of documentation of quarterly reviews with staff were completed during the first and third quarters of 2023 and revealed a lack of documentation of quarterly reviews with residents was completed the first quarter of 2023. The operator failed to ensure the EMP was reviewed with staff and residents on a quarterly basis.	S3280		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive	S3298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3298	Continued From page 22 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 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 23 residents. All 23 residents ate food prepared in the same kitchen. The operator failed to ensure food items were served at the proper temperature. Findings included: - Observation on 04/10/24 at 01:52 PM revealed lack of food temperatures documented by staff. On 04/10/24 at 01:55 PM Dietary Staff D stated she used to take food temperatures but did not document them anywhere.	S3298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3298	Continued From page 23 The October 2021"Food Preparation and Service" policy documented, "The temperatures of foods ...are monitored throughout the meal by food and nutrition services staff. " 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 operator 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 23 residents. All 23 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3299	Continued From page 24 acceptable temperatures according to food safety guidelines. Findings included: - Observation on 04/10/24 at 01:52 PM revealed lack of refrigerator/freezer temperatures documented by staff. On 04/10/24 at 01:55 PM Dietary Staff D stated she did not document freezer/refrigerator temperatures. The October 2021 "Refrigerators and Freezers" policy documented, "Monthly tracking sheets for all refrigerators and freezers will be posted to record temperature ...Food Service Supervisors or designated employees will check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening." 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, sanitary, and comfortable environment for	S3305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3305	Continued From page 25 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3305	Continued From page 26 The facility had a census of 23 residents. All 23 residents ate food prepared in the same kitchen. The operator failed to ensure sanitary conditions for food service by not ensuring hot water temperature and chemical strengths were documented daily. Findings included: - Observation on 04/10/24 at 01:52 PM revealed lack of dishwasher temperatures or chemical strength documented by staff. On 04/10/24 at 01:55 PM Dietary Staff D stated she did not know anything about documenting dishwasher water temperature or chemical strength. The October 2021 "Dishwashing Machine Use" policy documented, "A supervisor will check the dishwashing machine for proper concentrations of sanitizer solution ...check temperatures using the machine gauge with each dishwashing machine cycle, and will record the results in a facility approved log ..." The operator failed to ensure sanitary conditions in the kitchen by failing to ensure documentation of hot water and chemical sanitizer strength was logged daily.	S3305		
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	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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 27	S3310		

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 23 residents. Based on record review and interview the operator 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 five newly hired staff records revealed the following:
"Certified Medication Aide" (CMA) C was hired on 01/01/23 had a TB Symptom Screening Questionnaire and a two-step TB skin test (TST) completed 17 days late.

"Certified Nurse Aide" (CNA) was hired on 12/18/23 had a one-step TST completed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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 28	S3310		

08/21/23 by an outside provider. The facility did not complete another one-step TST upon hire.

"Licensed Nurse" (LPN) A was hired on 01/15/24 did but lacked documentation of a two-step TST completed upon hire.

Ashley MacDonald, Cook Dietary Staff F was hired on 12/26/23 lacked documentation of a two-step TST completed upon hire.
CMA G was hired on 11/18/23 had two-step TST completed 88 days late on 02/21/24 .

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 ...If a new employee provides satisfactory documentation of receiving a single TST within 6 months prior to employment that read not positive, the employee shall only be required to have a single TST within 7 days of employment."

The operator 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)103 admitted to the facility on 07/17/14.

Review of medical records revealed R103 did not have a TB Symptom Screen Questionnaire or a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE	440 N 4TH STREET CLEARWATER, KS 67026

(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 29 two-step TST completed annually during 2023. On 04/11/24 at 01:08 PM Administrative Nurse A stated she could not find documentation a TB screening questionnaire was completed on R103 for 2023. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each resident ...shall have an annual TB symptom screen that included the components of the Tuberculosis Symptom Screen Review Questionnaire." The operator 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		