STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175223	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chase County Care and Rehab	612 Walnut Cottonwood Falls, KS 66845

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 28560 The facility reported a census of 33 residents with four residents selected for review. Based on interview and record review, the facility failed to conduct reference checks for five of five employees reviewed to ensure no abuse to the residents of the facility. Findings included: - Review of the following personnel files for the following staff hired within the past year from 06/26/23 to 06/26/24, revealed lack of documentation for reference checks for the following staff: 1. Certified Nurse Aide (CNA) M with hire date of 02/08/24. 2. CNA N with a hire date of 02/026/24. 3. CNA O with a hire date of 11/2023. 4. CNA P with a hire date of 03/27/24. 5. Housekeeping staff U with a hire date of 05/21/24. Interview, on 06/26/24 at 03:30 PM, with Administrative Staff A, confirmed lack of documentation that reference checks were completed. The facility policy Abuse Prevention Program, Screening of Employees reviewed 09/2023, instructed staff pre-employment screening to consist of at a minimum employment history, information from former employers as available and documentation of status and any disciplinary actions from licensing or registration boards or registries. The facility failed to thoroughly screen employees by completion of reference checks for the prevention of abuse, neglect, and exploitation for the residents of the facility.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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