

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/14/2017
NAME OF PROVIDER OR SUPPLIER CARE TOUCH HOMES PLUS, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11206 WEST 72ND TERRACE SHAWNEE, KS 66203		
(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 an initial survey at the above named home plus facility conducted on 8-9-17, 8-10-17 and 8-14-17.	S 000		
S5029 SS=F	26-42-101 (g) Availability of policies and procedures (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(g) The facility reported a census of 3 residents. The sample included 3 residents. The Operator/LPN (Licensed Practical Nurse) failed to post a notice of availability of policies and procedures in a place readily accessible to residents as evidenced by observation and interview and affecting all residents, legal representative of residents, case managers and families. Findings included: - Observation during entrance tour of facility on 8-9-17 from 11:45 am to 1:15 pm revealed the facility lacked a posted notice of availability of policies and procedures in a place readily accessible to residents.	S5029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S5029	Continued From page 1 Interview on 8-9-17 at 1:15 pm with Operator/LPN confirmed no notice of availability of policies and procedures posted. For all residents, the Operator/LPN failed to post a notice of availability of policies and procedures in a place readily accessible to residents.	S5029		
S5050 SS=F	26-42-101 (k) Ombudsman (k) Ombudsman. Each administrator or operator shall ensure the posting of the names, addresses, and telephone numbers of the Kansas department on aging and the office of the long-term care ombudsman with information that these agencies can be contacted to report actual or potential abuse, neglect, or exploitation of residents or to register complaints concerning the operation of the home. The administrator or operator shall ensure that this information is posted in a common area accessible to all residents and the public. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(k) The facility reported a census of 3 residents. The Operator/LPN (Licensed Practical Nurse) failed to ensure the posting of the name, address, and telephone number of the Kansas Department for Aging and Disability Services and the Office of the Long-Term Care Ombudsman in a common area readily accessible to all residents and the public, with information that this agency could be contacted to report actual or potential abuse, neglect, or exploitation of residents or to register complaints concerning the operation of the home,	S5050		

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S5050	Continued From page 2 as evidenced by observations and interviews, for 1 of 1 home plus facility and affecting all residents and the public. Findings included: - Observations on 8-9-17 from 11:45 am to 1:15 pm during a tour of the facility revealed no evidence of the posting of the contact information for the Kansas Department for Aging and Disability Services and the Office of the Long-Term Care Ombudsman in a common area readily accessible to all residents and the public, with information this agency could be contacted to report actual or potential abuse, neglect, or exploitation of residents or to register complaints concerning the operation of the home. Interview on 8-9-17 at 1:15 p.m., the Operator/LPN confirmed the home lacked a poster with contact information for the Kansas Department for Aging and Disability Services and the Office of the Long-Term Care Ombudsman. The Operator/LPN stated he/she would contact the department for this information. The Operator/LPN failed to ensure the posting of the name, address, and telephone number of the Kansas Department for Aging and Disability Services and the Office of the Long-Term Care Ombudsman in a common area readily accessible to all residents and the public, with information that this agency could be contacted to report actual or potential abuse, neglect, or exploitation of residents or to register complaints concerning the operation of the home.	S5050		
S5085 SS=E	26-42-201 (c) Functional Capacity Screen Reassessment	S5085		

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S5085	Continued From page 3 (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201 (c)(2) The facility reported a census of 3 residents. The sample included 3 residents. Based on record review and interview for 2 (#102, #104) of 3 sampled residents, the Operator/LPN (Licensed Practical Nurse) failed to ensure designated facility staff shall conduct a screening to determine the resident's functional capacity following a significant change in condition as defined in K.A.R. 26-39-100. Findings included: - Record review for Resident #102 revealed admission on 11-7-16 with diagnoses Hypertension, Chronic Atrial Fibrillation, Difficulty Walking, Muscle Weakness, and History of Fractured Right Femur. The Functional Capacity Screen (FCS) dated 11-7-16 recorded the resident unable to perform bathing, dressing, toileting, transfers, walking/mobility and management of medications/treatments; and supervision with eating. Occasionally incontinent of bladder.	S5085		

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S5085	Continued From page 4 Cognition: Problems with decision-making. Current problems/risks included: falls/unsteadiness, impaired vision, impaired decision-making. Interview on 8-10-17 at 9:56 am with Certified Staff C stated resident was able to dress and wash his/her upper body; required assistance with dressing and washing lower body. Interview on 8-10-17 at 1:37 pm with Operator/LPN stated when resident initially admitted to facility, had recently been discharged from rehab following a fall and fracture and required more assistance. He/She received therapy in order to become stronger and more independent. Confirmed resident was able to bathe and dress upper body and confirmed the record lacked documentation of re-assessment following a significant change in condition. - Record review for Resident #104 revealed admission on 11-7-16 with diagnoses Alzheimer's Dementia with Behaviors, and Hypertension. The Functional Capacity Screen (FCS) dated 11-7-16 recorded the resident unable to perform bathing, dressing, toileting, transfers, walking/mobility, eating and management of medications/treatments. Incontinent of bladder. Problems with all aspects of cognition and communication. Current problems/risks included falls/unsteadiness, impaired vision, impaired decision-making, wandering and socially inappropriate disruptive behavior. Observations of Resident on 8-9-17 and 8-10-17 during breakfast and lunch revealed resident feeding self and eating independently. Further	S5085		

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S5085	Continued From page 5 observation on 8-10-17 at 10:35 with hospice aide revealed resident able to ambulate with standby assistance from room to bathroom then from toilet to shower. Interview on 8-10-17 at 10:35 am with hospice staff stated resident is able to feed self, "just needs cueing to get him/her started with that first initial bite." Interview on 8-10-17 at 3:54 pm with Operator/LPN confirmed the resident was able to eat independently and occasionally required cueing to get started. Further confirmed resident is able to ambulate with stand by assistance at times. Requires physical assistance with wheelchair over carpeted areas in home. Stated FCS should have been coded as "2" for physical assist with walking/mobility and eating. For Residents #102 and #104, the Operator/LPN failed to ensure designated staff conducted a screening to determine the resident's functional capacity following a significant change in condition.	S5085		
S5116 SS=D	26-42-202 (d) NSA 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	S5116		

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S5116	Continued From page 6 legal representative, 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: KAR 26-42-202(d) The facility reported a census of 3 residents. The sample included 3 residents. Based on observation, record review and interview for 1 (#104) of 3 sampled residents, the Operator/LPN (Licensed Practical Nurse) failed to ensure the review and revision of the negotiated service agreement following any significant change in condition. Findings included: - Record review for Resident #104 revealed admission on 11-7-16 with diagnoses Alzheimer's Dementia with Behaviors, and Hypertension. The Functional Capacity Screen (FCS) dated 11-7-16 recorded the resident unable to perform bathing, dressing, toileting, transfers, walking/mobility, eating and management of medications/treatments. Incontinent of bladder. Problems with all aspects of cognition and communication. Current problems/risks included falls/unsteadiness, impaired vision, impaired decision-making, wandering and socially inappropriate disruptive behavior. The negotiated service agreement/healthcare service plan (NSA/H CSP) dated 11-7-16 recorded services for assistance with bathing, dressing, toileting, transfers, walking/mobility and eating.	S5116		

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S5116	Continued From page 7 Facility staff to administer and order medications. The NSA documented hospice services under Hospice A effective 11-7-17 (note: lacked documentation of who was responsible to pay the hospice provider). The NSA lacked documentation of change in hospice provider (including who was responsible to pay the hospice provider). The NSA further lacked documentation of nectar thickened liquids and who provides the thickener. Physician order dated 1-26-17: Discharge from (Hospice A). Admit to (Hospice B). Physician order dated 7-5-17: Change liquids to Nectar Thickened consistency for aspiration and coughing. Interview on 8-10-17 at 11:35 am with Operator/LPN confirmed the NSA lacked documentation of revision with changes to diet and hospice provider. Stated the hospice provides the thickener for resident's liquids. For Resident #104, the Operator/LPN failed to ensure revision of the negotiated service agreement following significant changes in care.	S5116		
S5126 SS=E	26-42-202 (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	S5126		

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S5126	Continued From page 8 by: KAR 26-42-202(h) The facility reported a census of 3 residents. The sample included 3 residents. Based on record review and interview for 2 (#102, #104) of 3 sampled residents, the Operator/LPN (Licensed Practical Nurse) failed to ensure each individual involved in the development of the negotiated service agreement shall sign the agreement. Findings included: - Record review for Resident #102 revealed admission on 11-7-16 with diagnoses Hypertension, Chronic Atrial Fibrillation, Difficulty Walking, Muscle Weakness, and History of Fractured Right Femur. The Functional Capacity Screen (FCS) dated 11-7-16 indicated the resident required health care services. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 11-7-16 recorded services for total assistance with bathing, dressing, toileting, transfers. Staff responsible for medication management. Resident uses wheelchair for mobility. The NSA lacked signature of resident and/or responsible party. Interview on 8-9-17 at 2:07 pm with Operator/LPN confirmed the NSA lacked documentation of signature of resident and/or responsible party. - Record review for Resident #104 revealed admission on 11-7-16 with diagnoses Alzheimer's	S5126		

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S5126	Continued From page 9 Dementia with Behaviors, and Hypertension. The Functional Capacity Screen (FCS) dated 11-7-16 indicated the resident required health care services. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 11-7-16 recorded services for assistance with bathing, dressing, toileting, transfers, walking/mobility and eating. Facility staff to administer and order medications. The NSA lacked signature of resident and/or responsible party. Interview on 8-10-17 at 11:35 am with Operator/LPN confirmed the NSA lacked documentation of signature of resident and/or responsible party. Facility policy for "Negotiated Service Agreement" stated: 8. Each individual involved in the development of the NSA shall sign the agreement. A copy of the initial agreement and any subsequent revisions shall be provided to the resident or the resident's legal representative." For Residents #102 and #104, the Operator/LPN failed to ensure each individual involved in the development of the negotiated service agreements signed the agreements.	S5126		
S5130 SS=D	26-42-202 (j) NSA Outside Resources (j) If a resident's negotiated service agreement includes the use of outside resources, the designated staff shall perform the following:	S5130		

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S5130	Continued From page 10 (1) Provide 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, with a list of providers available to provide needed services; (2) assist the resident, if requested, in contacting outside resources for services; and (3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-202 (j)(3) The facility reported a census of 3 residents. The sample included 3 residents. Based on observation, record review, interview for 1 (#102) of 3 sampled residents, the Operator/LPN failed to monitor the services provided by outside resources and act as an advocate for the resident if services did not meet professional standards of practice. Findings included: - Record review for Resident #102 revealed admission on 11-7-16 with diagnoses Hypertension, Chronic Atrial Fibrillation, Difficulty Walking, Muscle Weakness, and History of Fractured Right Femur. The Functional Capacity Screen (FCS) dated 11-7-16 indicated the resident required health care services. The Negotiated Service Agreement/Health Care Service Plan (NSA/H CSP) dated 11-7-16 recorded services for total assistance with	S5130		

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S5130	Continued From page 11 bathing, dressing, toileting, transfers. Staff responsible for medication management. Resident uses wheelchair for mobility. The NSA documented resident to receive home health services for physical therapy and occupational therapy from a home health agency starting on 11-10-16. The NSA lacked documentation date therapy ended. The NSA documented physical therapy by a home health agency which started on 1-9-17 and lacked documentation of when therapy ended. Nurse's Notes revealed the following: On 12-30-16 at 7:00 pm: "New orders per (physician) for Physical Therapy to evaluate and treat per resident and family request for strengthening and some independence. Resident states he/she needs more therapy to be able to do more for self if necessary." Signed by Operator/LPN. On 1-5-17 at 11:30 am: "Physical Therapy evaluation completed this morning and therapist to start on working with resident next week for physical therapy." Signed by Operator/LPN. The record lacked documentation from the home health provider and documentation by facility staff to show monitoring of outside resources for professional standards of practice. Facility policy for Negotiated Service Agreement stated the following: "9. Should the (resident's) NSA include the use of outside resources, (facility) will: c. Monitor the services by the outside resource and act as an advocate for (resident) when services do not meet professional standards of practice." Interview on 8-9-17 at 2:07 pm with Operator/LPN	S5130		

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S5130	Continued From page 12 confirmed the record lacked documentation to show monitoring of outside resources for professional standards of practice and documentation from the home health agency of provision of services. For Resident #102, the Operator/LPN failed to monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice.	S5130		
S5155 SS=F	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility identified a census of 3 residents. The sample included 3 residents. The Operator/LPN (Licensed Practical Nurse) failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the residents regarding use of side rails on beds to include safety assessments prior to use as evidenced by observation, record review and interview; and	S5155		

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S5155	Continued From page 13 affecting 3 (#102, #103, #104) of 3 sampled residents. Findings included: - Observations on 8-9-17 during entrance tour of facility revealed all resident rooms contained hospital beds with half rails attached to the bed frames. - Record review for resident #102 revealed admission on 11-7-16 with diagnoses Hypertension, Chronic Atrial Fibrillation, Difficulty Walking, Muscle Weakness, and History of Fractured Right Femur. The Functional Capacity Screen (FCS) dated 11-7-16 indicated the resident required health care services. The Functional Capacity Screen (FCS) dated 11-7-16 recorded the resident unable to perform bathing, dressing, toileting, transfers, walking/mobility and management of medications/treatments; and supervision with eating. Occasionally incontinent of bladder. Cognition: Problems with decision-making. Current problems/risks included: falls/unsteadiness, impaired vision, impaired decision-making. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 11-7-16 recorded services for total assistance with bathing, dressing, toileting, transfers. Staff responsible for medication management. Resident uses wheelchair for mobility. The NSA/HCSP lacked indication and use of a half rail on bed including documentation of a safety assessment prior to use of the rail. The nurse's notes lacked documentation of use of	S5155		

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(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
S5155	Continued From page 14 side rail. Observation on 8-10-17 at 11:00 am of resident #102 in bed revealed him/her using rail to assist staff with putting on pants. Rail has a bell on it which resident uses to request assistance. - Record review for resident #103 revealed admission on 4-1-17 with diagnoses Hypertension, Alzheimer's Dementia without Behavioral Disturbance, Pernicious Anemia, Atrial Fibrillation and Arthritis. The Functional Capacity Screen (FCS) dated 4-1-17 recorded the resident unable to perform bathing, dressing, toileting and management of medications/treatments; and required supervision with transfers, walking/mobility and eating. Occasionally incontinent of bladder. Problems with all aspects of cognition. Current problem/risks identified included falls/unsteadiness, impaired decision-making and wandering. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 4-1-17 recorded services for total assistance with bathing, dressing, toileting; moderate assistance with transfers. Family will order and deliver medications, facility staff to administer medications. The NSA/HCSP lacked indication and use of a half rail on bed including documentation of a safety assessment prior to use of the rail; and use of a bed alarm. The nurse's notes lacked documentation of use of side rail. Observations on 8-9-17 and 8-10-17 during	S5155			

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S5155	Continued From page 15 survey revealed resident alert and able to make needs known by calling out for staff when he/she needed something. - Record review for resident #104 revealed admission on 11-7-16 with diagnoses Alzheimer's Dementia with Behaviors, and Hypertension.. The Functional Capacity Screen (FCS) dated 11-7-16 recorded the resident unable to perform bathing, dressing, toileting, transfers, walking/mobility, eating and management of medications/treatments. Incontinent of bladder. Problems with all aspects of cognition and communication. Current problems/risks included falls/unsteadiness, impaired vision, impaired decision-making, wandering and socially inappropriate disruptive behavior. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 11-7-16 recorded services for assistance with bathing, dressing, toileting, transfers, walking/mobility and eating. Facility staff to administer and order medications. The NSA/HCSP lacked indication and use of a half rail on bed including documentation of a safety assessment prior to use of the rail. The nurse's notes lacked documentation of use of side rail. Observations on 8-9-17 and 8-10-17 during survey revealed resident to be unable to make needs known. Did not speak and unable to talk in complete sentences. Would be unable to request that rail be put down or to put rail down independently.	S5155		

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S5155	Continued From page 16 Interview on 8-10-17 at 12:20 pm with Operator/LPN stated Resident #102 uses the rail to turn and position self in bed and confirmed he/she is able to request rail to be put down; Resident #103 uses the rail for positioning self in bed and is able to make needs known to staff; Resident #104 uses the rail for positioning and security. Stated Resident #104 holds onto the rail for security and uses the rail for support when staff transferred him/her out of the bed. The Operator/LPN stated did not have a policy and procedure for use of side rails on beds. For residents #102, #103, #104, the Operator/LPN failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the residents regarding use of side rails on beds to include safety assessments prior to use.	S5155		
S5161 SS=F	26-42-204 (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: KAR 26-42-204(d) The facility reported a census of 3 residents. The sample included 3 residents. The Operator/LPN failed to ensure the negotiated service agreement contained the name of the licensed nurse responsible for the implementation	S5161		

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S5161	Continued From page 17 and supervision of the health care services plan as evidenced by record review and interview for 3 (#102, #103, #104) of 3 sampled residents. Findings included: - Record review for resident #102 revealed admission on 11-7-16 with diagnoses Hypertension, Chronic Atrial Fibrillation, Difficulty Walking, Muscle Weakness, and History of Fractured Right Femur. The Functional Capacity Screen (FCS) dated 11-7-16 indicated the resident required health care services. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 11-7-16 recorded services for total assistance with bathing, dressing, toileting, transfers. Staff responsible for medication management. Resident uses wheelchair for mobility. The NSA failed to designate the name of the licensed nurse responsible for the implementation and supervision of health care services. - Record review for resident #103 revealed admission on 4-1-17 with diagnoses Hypertension, Alzheimer's Dementia without Behavioral Disturbance, Pernicious Anemia, Atrial Fibrillation and Arthritis. The Functional Capacity Screen (FCS) dated 4-1-17 indicated the resident required health care services. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 4-1-17 recorded	S5161		

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S5161	Continued From page 18 services for total assistance with bathing, dressing, toileting; moderate assistance with transfers. Family will order and deliver medications, facility staff to administer medications. The NSA failed to designate the name of the licensed nurse responsible for the implementation and supervision of health care services. - Record review for resident #104 revealed admission on 11-7-16 with diagnoses Alzheimer's Dementia with Behaviors, and Hypertension.. The Functional Capacity Screen (FCS) dated 11-7-16 indicated the resident required health care services. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 11-7-16 recorded services for assistance with bathing, dressing, toileting, transfers, walking/mobility and eating. Facility staff to administer and order medications. The NSA failed to designate the name of the licensed nurse responsible for the implementation and supervision of health care services. Interview on 8-9-17 at 12:55 pm with Operator/LPN stated all residents receive health care services; confirmed that he/she is the nurse responsible for the health care services at the facility and the NSA failed to designate the name of the licensed nurse responsible for the implementation and supervision of the plan. For all residents, the Operator/LPN failed to ensure the negotiated service agreement	S5161		

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S5161	Continued From page 19 contained the name of the licensed nurse responsible for the implementation and supervision of the health care services plan.	S5161		
S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(f) The facility reported a census of 3 residents. The sample included 3 residents. The Operator/LPN (Licensed Practical Nurse) failed to ensure all food shall be stored under safe and sanitary conditions as evidenced by observation and interview and affecting all residents. Findings included: - Observation during tour of facility with operator on 2-15-17 at 2:00 pm revealed a residential style side by side refrigerator/freezer in the garage which lacked thermometers. A chest type freezer in the kitchen also lacked a thermometer. A residential style three-door refrigerator/freezer in the kitchen contained the following items which lacked labels and/or dates:	S5195		

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S5195	Continued From page 20 plastic container with leftover spaghetti; Ziploc baggie with white substance. Operator/LPN identified as "African corn"; Ziploc baggie with cut up onion; bowl covered with plastic wrap contained leftover cooked peas. Cabinet with dry foods contained two Ziploc baggies which contained cereal and a white substance. Both baggies lacked labels and dates. Interview on 8-9-17 at 12:21 pm with Operator/LPN confirmed the refrigerator/freezer and chest freezer lacked thermometers and identified the baggies in the cabinet as containing corn flakes and sugar. further confirmed the items which lacked labels and/or dates. For all residents, the Operator/LPN failed to ensure all food shall be stored safely.	S5195		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (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 home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' 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	S5215		

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S5215	Continued From page 21 shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3)(4) The facility reported a census of 3 residents. The sample included 3 residents. The Operator/LPN (Licensed Practical Nurse) failed to ensure disaster and emergency preparedness by ensuring quarterly review of the home's emergency management plan with employees and residents; and performance of an emergency evacuation drill to a secure location as evidenced by record review and interview and affecting all residents and staff. Findings included: - Review of facility emergency management plan on 8-10-17 with Operator/LPN revealed the plan lacked documentation of quarterly review with residents and staff; and documentation of an emergency evacuation drill to a secure location. Facility policy stated the following: "Environmental or Employee Emergencies: Every three months, (facility) will do an emergency drill with staff and residents that includes evacuation of (facility). New employees at the time of employment will be oriented to (facility's) emergency management plan. Residents new to the (facility) will be oriented to the emergency management plan." The policy lacked documentation of requirement for quarterly review of the emergency management plan with employees and residents.	S5215		

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S5215	Continued From page 22 Interview on 8-10-17 at 12:33 pm with Operator/LPN confirmed the plan lacked documentation of quarterly review with residents and staff. Stated he/she had performed an evacuation drill with residents and one staff member in which they were evacuated outside to the mailbox but failed to document the drill. The Operator/LPN failed to ensure disaster and emergency preparedness by ensuring quarterly review of the home's emergency management plan with employees and residents; and performance of an emergency evacuation drill to a secure location.	S5215		
S5230 SS=F	26-42-207 (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; (c) Each administrator or operator shall ensure the home ' 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(b)(5)(6)(c)	S5230		

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S5230	Continued From page 23 The facility reported a census of 3 residents. The sample included 3 residents. The Operator/LPN (Licensed Practical Nurse) failed to ensure the home's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, as evidence by record review and interview for 3 (#102, #103, #104) of 3 sampled residents and 4 (B, C, D, E) of 5 sampled staff. Findings included: - Record reviews revealed the following: Resident #102 with date of admission on 11-7-16: the record lacked documentation of tuberculosis (TB) skin testing. Resident #103 with date of admission on 4-1-17: the record lacked documentation of TB skin testing. Resident #104 with date of admission on 11-7-16: the record lacked documentation of TB skin testing. - Interviews on 8-9-17 at 2:07 pm (Resident #102), 3:05 pm (Resident #103 and #104) with Operator/LPN confirmed the records lacked documentation of TB skin testing. - Personnel record review on 8-10-17 at 11:57 am with Operator/LPN revealed the following: Certified Staff B with date of hire 4-6-17: Chest X-ray dated 11-3-16. The record lacked documentation of a TB symptom screening questionnaire. Certified Staff C with date of hire 1-8-17: TB skin testing on 9-13-16 with result 0.0 mm (millimeters of induration) "negative". The record lacked documentation of a TB symptom screening questionnaire and results of a second step. Certified Staff D with date of hire 4-14-17: The	S5230		

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S5230	Continued From page 24 record contained documentation of a 2 view chest x-ray dated 2-18-16. The record lacked documentation of a chest x-ray within 6 months of date of hire and a TB symptom screening questionnaire. Certified Staff E with date of hire 11-29-16: The record lacked documentation of TB testing and a TB symptom screening questionnaire. Facility "Infection Control" policy stated: "7. Tuberculosis skin testing of each new resident and employee as soon as they are accepted to (facility) or hired for (facility). Employment and residency will not occur until test results come back showing that there is no infection. (Facility) shall follow the Tuberculosis (TB) Guidelines for Adult Care Homes June 2013 which are based on Center for Disease Control and preventions 'Guidelines for preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings 2005'..." Interview on 8-10-17 at 11:57 am during personnel record review with Operator/LPN confirmed the above personnel files lacked documentation of a TB symptom screening questionnaire and/or results of skin testing. For Residents #102, #103, #104 and Certified Staff B, C, D, and E, the Operator/LPN failed to ensure the home's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S5230		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff	S5258		

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S5258	Continued From page 25 records shall contain the following information: (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 carehome; 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 work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(d)(1) The facility reported a census of 3 residents. The sample included 3 residents. The facility identified 5 employees hired since opening of home, with 5 certified staff reviewed. The Operator/LPN failed to ensure the employee records contained evidence of licensure or certification for each employee performing a function that requires specialized education or training and verified before providing care to residents as evidenced by record review and interview for 5 (B, C, D, E, F) of 5 certified staff reviewed.	S5258		

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S5258	Continued From page 26 Findings included: - Record review on 8-10-17 at 11:57 am of employee records with Operator/LPN revealed the following: Record reviews for certified staff B (date of hire 4-6-17), certified staff C (date of hire 1-8-17), certified staff D (date of hire 4-14-17), certified staff E (date of hire 11-29-16) and certified staff F (date of hire 12-5-16) revealed the nurse aid registry form lacked the date when it was checked. Facility policy stated: "Staff Qualifications and Employment Screening: 1. Employee records shall contain evidence of licensure, registration or certification of all full-time, part-time and consultant staff. 4.-All CNAs (certified nurse aides) and CMAs (certified medication aides) will be checked through the Kansas Nurse Aide Registry before being hired." Interview on 8-10-17 at 11:57 am with Operator/LPN confirmed the registry forms lacked dates when checked. For all residents, the Operator/LPN failed to ensure the employee records contained documentation that the registry was checked before providing care to residents.	S5258		
S5310 SS=D	26-42-205 (e) (f) (g 1 - 3) Medication Orders, Ordering, Labeling (e) Medication orders. Only a licensed nurse or a licensed pharmacist may receive verbal orders	S5310		

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S5310	Continued From page 27 for medication from a medical care provider. The licensed nurse shall ensure that all verbal orders are signed by the medical care provider within seven working days of receipt of the verbal order. (f) Standing orders. Only a licensed nurse shall make the decision for implementation of standing orders for specified medications and treatments formulated and signed by the resident's medical care provider. Standing orders of medications shall not include orders for the administration of schedule II medications or psychopharmacological medications. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(e) The facility reported a census of 3 residents. The sample included 3 residents. Based on record review and interview for 1 (#103) of 3 sampled residents, the licensed nurse failed to ensure all verbal orders were signed by the medical care provider within seven working days of receipt of the verbal order. Findings included: - Record review for resident #103 revealed admission on 4-1-17 with diagnoses Hypertension, Alzheimer's Dementia without Behavioral Disturbance, Pernicious Anemia, Atrial Fibrillation and Arthritis. The Functional Capacity Screen (FCS) dated 4-1-17 recorded the resident unable to perform management of medications and treatments.	S5310		

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NAME OF PROVIDER OR SUPPLIER CARE TOUCH HOMES PLUS, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11206 WEST 72ND TERRACE SHAWNEE, KS 66203		
(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
S5310	Continued From page 28 The Negotiated Service Agreement/Health Care Service Plan (NSA/H CSP) dated 4-1-17 recorded resident's family will order and deliver medications, facility staff to administer medications. Telephone orders recorded the following: 4-1-17: Admit to (facility). Protine/INR (International Normalized Ratio) every 2 weeks start 4-10-17. The order was signed by physician on 6-19-17. 5-4-17: Donepezil HCL 5 mg (milligrams) by mouth 1 tablet at bedtime for Dementia. The order was signed by physician 6-19-17. Interview on 8-10-17 at 1:15 pm with Operator/LPN confirmed the telephone orders lacked signature of the ordering physician within 7 working days of receipt of the order. For Resident #103, the Operator/LPN failed to ensure all verbal orders were signed by the medical care provider within seven working days of receipt of the verbal order.	S5310		
S5313 SS=E	26-42-205 (g) (3) Over the counter medication (g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and	S5313		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/14/2017
NAME OF PROVIDER OR SUPPLIER CARE TOUCH HOMES PLUS, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11206 WEST 72ND TERRACE SHAWNEE, KS 66203		
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S5313	Continued From page 29 the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(3) The facility reported a census of 3 residents. The sample included 3 residents. Based on observation and interview for 2 (#102, #103) of 3 sampled residents, the Operator/LPN (Licensed Practical Nurse) failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on each resident's over-the-counter medication package. Findings included: - Review of the resident roster revealed all 3 residents received medication management. Observation on 8-9-17 at 12:22 pm of medication cabinet revealed the following open over-the-counter medications in resident's plastic bins: For Resident #102: Natural Laxative 8.6 mg (milligrams) For Resident #103: Vitamin D3 2000 IU (International Units) gummies. Interview on 8-9-17 at 12:25 pm with Operator/LPN confirmed the over the counter medications lacked resident names on the containers. For Residents #102 and #103, the Operator/LPN failed to ensure the full name of the resident on each resident's over-the-counter medication	S5313		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/14/2017
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S5313	Continued From page 30 package.	S5313		