STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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 at the above home plus facility on 6-23-16, 6-27-16, 6-28-16, 6-29-16, and 6-30-16.	S 000		
S5028 SS=D	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(3)(A)	S5028		

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
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5028	Continued From page 1 The facility reported a census of 4 residents. The sample included 3 residents. Based on record review and interview for 1 (#200) of 3 residents sampled, the operator failed to report an allegation of abuse or neglect to the department within 24 hours and further failed to start an investigation when he/she received notice of an alleged violation. Findings included: - Record review for resident #200 revealed an admit date of 1-29-15 with diagnoses of dementia, macrocephaly, osteoarthritis, hypertension, muscle weakness, vertigo, and edema. The FCS dated 2-1-15 revealed resident #200 independent with eating, communication, required supervision with dressing, physical assistance with bathing, toileting, transfer, walking/mobility, bladder incontinence, unable to manage medications/treatments, experienced short term memory loss, memory recall, decision making, impaired decision making, and falls/unsteadiness. The negotiated service agreement (NSA) dated 2-1-15 recorded resident required physical assistance with toileting, transfer, bladder incontinence, and experienced falls/unsteadiness. The medical progress notes recorded the following: 4-19-16 at 7:30 a.m., "Resident to toilet with assistance by staff. . . .While staff assisting resident ' s roommate, resident tried to transfer	S5028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5028	Continued From page 2	S5028		

alone and fell on bottom and hit right knee on wall. . . " Signed Owner/Operator/Certified Medication Aide (CMA).

4-19-16 at 1:10 p.m., "Resident up to bathroom and needed more assistance than regularly. Knee looks a little swollen from earlier fall. Nurse and family notified. Nurse will be in to see resident. " Signed Owner/Operator/CMA.

4-19-16 at 4:30 p.m., "Resident assessed post fall. Alert and oriented. Able to make needs known. ROM performed. Complained of minimal pain in right knee. A bit swollen compared to left knee. . . . Instructed staff to monitor swelling, if gets worse to call the nurse." Signed registered nurse.

4-24-16 7:00 a.m. to 7:00 p.m. (no actual clock time) " . . . Staff noticed swollen ankle. Resident feels he/she must of turned ankle with fall (4-19-16). . . .Resident stated knee does not hurt, ankle has pain when touched. " Signed Owner/Operator/CMA.

House call Medical Services recorded on 4-26-16: Chief complaint: fall with ankle pain.

History of present illness: Saw patient today at facility at request of staff for fall follow up (from (from 4-19-16). Resident was sitting on toilet and tried to transfer self and fell. Resident bumped knee and landed on floor. Complained of pain, swelling, and inability to bear weight since then. Resident has bruising, edema, pain to right ankle. Staff has been putting ice on right ankle. Extremities: Pain with palpation over medial and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5028	Continued From page 3 lateral malleolus to right ankle. Edema and ecchymosis to right ankle. Unable to perform passive range of motion (ROM) without significant pain. Plan: Fall with pain/swelling to right ankle, will get X-ray of ankle (fall 4-19-16). Ice and elevate. Ibuprofen 400 milligrams two times a day for five days then as needed. Administer ibuprofen for pain along with Tylenol. The record contained X-ray results dated 4-26-16 that recorded the following: Reason/History: Pain and swelling after fall injury. Unable to bear weight. Findings: Fracture medial malleolus and cortical fracture off tip of lateral malleolus. Soft tissue swelling is noted. Medical progress notes further recorded: 5-2-16 10:20 a.m. called state to report fall on (4-19-16). Signed owner/operator/CMA. Interview on 6-27-16 at 2:00 p.m. with Owner/operator/CMA stated called the department and reported fall (on 4-19-16) on 5-2-16 and started an investigation. For resident #200, the operator failed to report each allegation of abuse or neglect to the department within 24 hours and further failed to start an investigation when he/she received notification of an alleged violation.	S5028		
S5085 SS=E	26-42-201 (c) Functional Capacity Screen Reassessment	S5085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5085	Continued From page 4 (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)(1)(2) The facility reported a census of 4 residents. The sample included 3 residents. Based on record review, interview, and observation for 2 (#200 #300) of 3 residents sampled, the designated staff failed to conduct a screening to determine the resident's functional capacity screen (FCS) at least every 365 days. Findings included: - Record review for resident #200 revealed an admit date of 1-29-15 with diagnoses of dementia, macrocephaly, osteoarthritis, hypertension, muscle weakness, vertigo, and edema. The FCS dated 2-1-15 revealed resident #200 independent with eating, communication, required supervision with dressing, physical assistance with bathing, toileting, transfer, walking/mobility, bladder incontinence, unable to manage medications/treatments, experienced short term memory loss, memory recall, decision making, impaired decision making, and falls/unsteadiness.	S5085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5085	Continued From page 5 The record lacked a completed FCS every 365 days. Interview on 6-23-16 at 2:20 p.m. with operator/owner/CMA stated and confirmed the FCS was not conducted every 365 days. Telephone interview on 6-28-16 at 8:40 a.m. with registered nurse stated and confirmed the record lacked a completed FCS every 365 days. - Record review for resident #300 revealed an admit date 5-15-14 with diagnoses of insulin dependent diabetic, alzheimer's, coronary artery disease, hypertension, dementia with behavioral disturbances. The FCS dated 10-29-14 recorded resident independent with transfer, eating, required supervision with walking/mobility, physical assistance with bathing, dressing, toileting unable to manage medications/treatments, experienced short-term memory loss, memory recall, impaired decision making, wandering, and falls/unsteadiness. The record lacked a completed FCS every 365 days. Interview on 6-23-16 at 2:20 p.m. with operator/owner/CMA stated and confirmed the FCS was not conducted every 365 days. Telephone interview on 6-28-16 at 8:40 a.m. with registered nurse stated and confirmed the record lacked a completed FCS every 365 days. For residents #200 and #300, the designated staff failed to conduct a screening to determine the resident's FCS at least every 365 days.	S5085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5116 SS=E	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 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 4 residents. The sample included 3 residents. Based on record review and interviews for 2 (#200 and #300), the operator failed to ensure the review and revision of each negotiated service agreement (NSA) at least once every 365 days. Findings included: - The functional capacity screen dated 2-1-15 revealed resident #200 independent with eating, communication, required supervision with dressing, physical assistance with bathing, toileting, transfer, walking/mobility, bladder incontinence, unable to manage medications/treatments, experienced short term memory loss, memory recall, decision making,	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5116	Continued From page 7 impaired decision making, and falls/unsteadiness. The NSA dated 2-1-15 recorded resident #200 was independent with eating, required supervision with dressing, physical assistance with bathing, toileting, transfer, walking/mobility, bladder incontinence experienced short term memory, memory recall, impaired decision making falls/unsteadiness and certified medication aide or licensed nurse will administer medications/treatments. The record lacked a NSA at least every 365 days. Interview on 6-23-16 at 2:15 p.m. with owner/operator/certified medication aide (CMA) stated and confirmed the NSA was not reviewed or revised every 365 days. - Record review for resident #300 revealed an admit date 5-15-14 with diagnoses of insulin dependent diabetic, Alzheimer ' s, coronary artery disease, hypertension, dementia with behavioral disturbances. The FCS dated 10-29-14 recorded resident independent with transfer, eating, required supervision with walking/mobility, physical assistance with bathing, dressing, toileting, unable to manage medications/treatments, experienced short-term memory loss, memory recall, impaired decision making, wandering, and falls/unsteadiness. The NSA dated 10-28-14 recorded resident physical assistance with bathing, dressing, toileting, gait belt with two staff for mobility/walking, one person assist for transfer, impaired decision making due to dementia, experienced falls/unsteadiness.	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5116	Continued From page 8 The record lacked a NSA at least every 365 days. Interview on 6-23-16 at 2:15 p.m. with owner/operator/CMA stated and confirmed the NSA was not reviewed/revised every 365 days. For residents #200 and #300, the operator failed to ensure the review and revision of each NSA at least once every 365 days.	S5116		
S5171 SS=E	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204 (i) The facility reported a census of 4 residents. The sample included 3 residents. Based on record review, interview, and observation for 1 (#200) of 3 residents sampled, the designated staff failed ensure the resident received health care service in accordance with standards of practice when certified staff failed to seek guidance from the licensed nurse for assessments and the licensed nurse failed to conduct follow up assessments and ensure the medical care providers orders were implemented. Findings included: - Record review for resident #200 revealed an admit date of 1-29-15 with diagnoses of	S5171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5171	Continued From page 9	S5171		

dementia, macrocephaly, osteoarthritis, hypertension, muscle weakness, vertigo, and edema.

The FCS dated 2-1-15 revealed resident #200 independent with eating, communication, required supervision with dressing, physical assistance with bathing, toileting, transfer, walking/mobility, bladder incontinence, unable to manage medications/treatments, experienced short term memory loss, memory recall, decision making, impaired decision making, and falls/unsteadiness.

The record lacked an annual FCS every 365 days.

The medical progress notes recorded the following:

4-19-16 at 7:30 a.m., " Resident to toilet with assistance by staff. Routine daily, resident will let staff know when ready to get off toilet. While staff assisting resident ' s roommate, resident tried to transfer alone and fell on bottom and hit right knee on wall. Vital signs taken 150/60, pulse 92, respirations 18, temperature 98.5. Resident said does not have any pain to body. No visual appearance of injury. Resident was assisted to chair. Nurse and family notified. Staff will monitor throughout day. " Signed Owner/Operator/Certified Medication Aide (CMA).

Owner/operator/CMA failed to seek guidance from licensed nurse prior to moving resident following a fall.

4-19-16 at 1:10 p.m., " Resident up to bathroom and needed more assistance than regularly. Knee looks a little swollen from earlier fall. Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5171	Continued From page 10	S5171		

and family notified. Nurse will be in to see resident. " Signed Owner/Operator/CMA.

4-19-16 at 4:30 p.m., "Resident assessed post fall. Alert and oriented. Able to make needs known. ROM performed. Complained of minimal pain in right knee. A bit swollen compared to left knee. New orders noted. Resident takes Tylenol for pain. Instructed staff to monitor swelling, if gets worse to call the nurse." Signed registered nurse.

Licensed nurse failed to notify medical care provider regarding change in condition.

4-19-16 7:00 a.m. to 7:00 p.m. (no actual clock time). No problems reported from night shift other than accident this a.m. No problems, will monitor right knee for redness and swelling. Ate well. " Certified staff C.

4-20-16 7:00 a.m. to 7:00 p.m. (no actual clock time). " No problems reported throughout the night. Ice packs to right knee throughout the shift. No redness, swelling gone down. Resident ate well. Will continue to monitor. " Certified staff C.

4-21-16 7:00 a.m. to 7:00 p.m.(no actual clock time) " Resident knee has went down from swelling. Resident is transferring a lot better. . . no problems or concerns at this time. " Signed Owner/Operator/CMA.

4-24-16 7:00 a.m. to 7:00 p.m. (no actual clock time) " Resident had a good night. No problems reported. Resident had a good day. Staff noticed swollen ankle. Resident feels he/she must of turned ankle with fall (4-19-16). Nurse in to see

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5171	Continued From page 11	S5171		

resident ankle. (no documentation from nurse). Awaiting call back from medical care provider for directions for ankle. Resident stated knee does not hurt, ankle has pain when touched. " Signed Owner/Operator/CMA.

Telephone interview on 6-29-16 at 10:10 a.m. with registered nurse stated owner/operator/CMA notified the medical care provider. Confirmed no documentation in record of assessment.

4-25-16 7:30 a.m. " (medical care provider) notified and instructed staff to monitor ankle. Keep ankle elevated with ice and to follow up with (him/her) tomorrow on updated with ankle. " Signed Owner/Operator/CMA.

Owner/operator/CMA failed to ensure the licensed nurse communicated with the medical care provider and received orders.

House call Medical Services recorded on 4-26-16: Chief complaint: fall with ankle pain.

History of present illness: Saw patient today at facility at request of staff for fall follow up (from (from 4-19-16). Resident was sitting on toilet and tried to transfer self and fell. Resident bumped knee and landed on floor. Complained of pain, swelling, and inability to bear weight since then. Resident has bruising, edema, pain to right ankle. Staff has been putting ice on right ankle. Extremities: Pain with palpation over medial and lateral malleolus to right ankle. Edema and ecchymosis to right ankle. Unable to perform passive range of motion (ROM) without significant pain.

Plan: Fall with pain/swelling to right ankle, will get X-ray of ankle (fall 4-19-16). Ice and elevate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5171	Continued From page 12	S5171		

Ibuprofen 400 milligrams two times a day for five days then as needed. Administer ibuprofen for pain along with Tylenol.

The record contained X-ray results dated 4-26-16 that recorded the following:

Reason/History: Pain and swelling after fall injury. Unable to bear weight.
Findings: Fracture medial malleolus and cortical fracture off tip of lateral malleolus. Soft tissue swelling is noted.

Medical progress notes further recorded:

5-2-16 7:00 a.m. to 7:00 p.m. (no actual clock time) " . . . Resident reports right ankle hurts with a 5 on pain scale of 1 - 10. PRN (as needed) Ibuprofen (for pain) administered to help pain. Will monitor. " Signed certified staff C.

5-3-16 7:00 a.m. to 7:00 p.m. (no actual clock time) " . . . Pain in right ankle controlled with ibuprofen and routine Tylenol. Will continue to monitor for pain and discomfort. " Signed certified staff C.

Telephone interview on 6-29-16 with registered nurse stated resident received ibuprofen two times a day with Tylenol times five days and had ibuprofen approximately two times a day rest of month with Tylenol. The certified staff did not call with each administered ibuprofen for pain.

5-5-16 7:00 a.m. to 7:00 p.m. (no actual clock time) " . . . Will continue to monitor for pain and discomfort. Ibuprofen given as needed. " Signed certified staff C.

No further documentation until 5-15-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5171	Continued From page 13 5-15-16 5:00 p.m. " Resident alert and forgetful. Able to make needs known. Still has cast on right leg. Resident will be going to orthopedic tomorrow. No complaint of discomfort. " 5-16-16 7:00 a.m. to 7:00 p.m. (no actual clock time) " . . . Out to orthopedic specialist this afternoon. Report right ankle healing well. Follow up appointment in two weeks. Continue to keep weight off foot. Will monitor. " Signed certified staff C. 5-17-16 7:00 a.m. to 7:00 p.m. (no actual clock time) " . . . Up to commode with assist of two staff. No other concerns. " Signed certified staff C. No further documentation about foot until 6-3-16. 6-3-16 7:00 a.m. to 7:00 p.m. " . . . Out to orthopedics appointment this morning. Cast removed. Will follow up with home health services for therapy. " Signed certified staff C. The HCS lacked interventions for care of resident with cast on due to fractured right foot and also lacked lacked intervetions for care of resident with right ankle splint after cast removed. 6-6-16 7:00 a.m. to 7:00 p.m. " Home health contacted for occupational therapy. " Signed certified staff C. 6-11-16 (no time) " Spoke with owner of home health company regarding therapy order that was faxed. Reassured med they will follow up with staff on Monday and get therapy started for resident. " Signed Owner/Operator/CMA.	S5171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5171	Continued From page 14 Documentation lacked evidence licensed nurse implemented physician orders. 6-13-16 (no time) " Resident alert and forgetful. Needs one person assist with care. Resident to start therapy this month. " Signed registered nurse. 6-14-16 7:00 a.m. to 7:00 p.m. (no actual clock time) " . . . Physical therapy in for therapy and did OK, was tired and frustrated afterwards. Will monitor. " Signed certified staff C. Order for physical therapy received on 6-3-16 and licensed nurse failed to ensure therapy service provided as ordered when the resident was not seen for therapy for 11 days. For resident #200, the designated staff failed to ensure the resident received health care service in accordance with standards of practice when certified staff failed to seek guidance from the licensed nurse for assessments and the licensed nurse failed to conduct follow up assessments and ensure the medical care providers orders were implemented.	S5171		
S5230 SS=E	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	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5230	Continued From page 15 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 26-42-207(b)(c) The facility reported a census of 4 residents. The sample included 3 residents. Based on record review and interview for 2 (#100, #300) of 3 residents sampled and 2 employee files reviewed, the operator failed to ensure the facility's compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Record review for resident #100 and #300 revealed the following: Resident #100 admitted to facility on 3-2-16. The record contained documentation of a TB skin test dated 11-13-15 and read on 11-16-15 with results negative. The record lacked the second step TB skin test. Resident #300 admitted to facility on 5-14-14. The record contained documentation of a two-step TB skin test dated 9-30-14 and read on 10-3-14 with negative results. The second step dated 10-28-14 and read on 10-31-14 with negative results. The record lacked an annual TB symptom screen consisting of completion of the	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5230	Continued From page 16 symptom review questionnaire. At 1:30 p.m. on 6-27-16, operator stated and confirmed resident #100 lacked a two-step TB skin test and resident #300 lacked an annual TB symptom screening. Review of employee files at 1:30 on 6-27-16 revealed the following: Employee file for registered nurse hired on 7-9-15 had an initial two step TB skin test dated 4-11-16 and read 4-13-16 with negative results. The employee record lacked a second step TB skin test. Employee file for certified staff B hired on 4-9-16 had an initial two step TB skin test dated 4-21-16 and read on 4-23-16 with negative results. The employee record lacked a second step TB skin test. Operator confirmed the lack of TB testing of the employees according to the department guidelines. For resident #100, #300, and 2 employees, the operator failed to ensure the facility's compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S5230		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5300	Continued From page 17 that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility reported a census of 4 residents. The sample included 3 residents. Based on record review and interview for 1 (#300) of 3 residents sampled, the operator failed to ensure medications administered to resident in accordance with medical care provider's written order, professional standards of practice and manufacturer's recommendations. Findings included: - Record review for resident #300 revealed diagnoses of insulin dependent diabetic, Alzheimer ' s coronary artery disease, and dementia with behavioral disturbances. The functional capacity screen dated10-29-14 recorded resident unable to manage medications and treatments. The negotiated service agreement dated 10-28-14 recorded certified medication	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087203	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM CARE HOMES	5701 E 17TH NORTH WICHITA, KS 67208

(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
S5300	Continued From page 18 aide/licensed staff to administer medications. Home health will administer insulin. The order from medical care provider dated 8-27-15 recorded lantus insulin 6 units subcutaneous (SQ) at bedtime (PM). The medication administration record recorded lantus insulin 6 units SQ every morning (AM). Interview on 6-27-16 at 1:15 p.m. with owner/operator/certified medication aide stated and confirmed the order for lantus insulin was for 6 units in PM and was administered in the AM by home health nurses. For resident #300, the operator failed to ensure medications administered to resident in accordance with medical care provider's written order, professional standards of practice and manufacturer's recommendations.	S5300		