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 _____	R-C 10/28/2014

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 citation represents the findings of a revisit for correction order 14-91 and ban on admissions 14-8 of the above home plus facility on 10/27/14 and 10/28/14.	{S 000}		
{S5105} SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus 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. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)(2)(3) The facility reported a census of 4 residents. The sample included 3 residents. Based on record review, observation, and interview for 2 (#1021 and #1020) of 3 residents sampled, the operator failed to ensure the development of a written negotiated service agreement based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's legal representative, the	{S5105}		

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 _____	R-C 10/28/2014

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
{S5105}	Continued From page 1	{S5105}		

case manager, and, if agreed to by the resident or the resident's legal representative, the resident's family, that included a description of services to be provided, the provider of the service, and the party responsible for payment when services were provided by an outside resource.

Findings included:

- Record review for resident #1021 revealed an admission date of 6/12/14 and diagnoses of renal failure, dementia, dysphagia, congestive heart failure, and hypertension.

The functional capacity screen dated 10/2/14 following a hospital stay indicated the resident was unable to perform bathing, toileting, transferring, mobility, and feeding self; was unable to perform management of medications and treatments; urinary incontinence, experienced impaired short-term memory, decision-making, and memory recall; and required a wheelchair for mobility. Licensed nurse #A documented under the comments section of the functional capacity screen that resident required total assistance to exit the building and documented "Speech therapy 10/9/14" in the ordered therapies and treatments section.

The record contained a medical care provider's order dated 10/15/14 for a mechanical soft diet with thin liquids.

The negotiated service agreement signed by the licensed nurse 6/12/14 and by the operator and the resident's family member on 10/27/14 lacked a description of services for speech therapy, the

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 _____	R-C 10/28/2014

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
{S5105}	Continued From page 2	{S5105}		

provider of speech therapy and the party responsible for payment. The negotiated service agreement lacked a description of services for a mechanical soft diet and that resident required total assistance to exit the building.

At 9:55 a.m. on 10/28/14, the operator stated that he/she reviewed the negotiated service agreement with the resident's family member last evening (10/27/14) and had the family member sign the agreement at that time. Operator confirmed the current negotiated service agreement lacked a description of services for speech therapy, mechanical soft diet, and resident's need for total assistance to exit the building. Operator confirmed the negotiated service agreement was not developed in collaboration with resident's family member.

The operator failed to ensure the development of a written negotiated service agreement for resident #1021 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, that included a description of services to be provided, the provider of the service, and the party responsible for payment when services were provided by an outside resource.

- Record review for resident #1020 revealed an admission date of 5/15/14 and diagnoses of Alzheimer's dementia, hypertension, and osteoarthritis.

The functional capacity screen dated 9/30/14, completed by licensed nurse #A, indicated the

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 _____	R-C 10/28/2014

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
{S5105}	Continued From page 3 resident required supervision with eating; physical assistance with bathing, dressing, toileting, and transferring; was unable to walk; unable to perform management of medications and treatments; was incontinent of urine; experienced impaired short-term memory, decision-making, and memory recall; and required a wheelchair for mobility. Licensed nurse #A documented "Physical assistance required to exit building." in the comments section of the functional capacity screen. The record contained a medical care provider's order dated 8/26/14 for resident to receive a mechanical soft diet with meat ground with gravy. At 3:00 p.m. on 10/27/14, observed resident #1020 in bed in the resident's room. One side of the bed was against the wall and a body pillow was positioned between the resident and the outer side of the bed. A twin mattress was on the floor beside the bed. Review of the resident's negotiated service agreement signed by the resident, operator, licensed nurse #B, and resident's family member on 5/15/14 lacked a description of services for resident's need for total assistance to exit the building and a mechanical soft diet with ground meat and gravy. The negotiated service agreement lacked a description of services for use of a mattress on floor beside bed and a body pillow between resident and edge of bed. At 9:55 a.m. on 10/28/14, the operator stated that he/she reviewed the resident's negotiated service agreement with the resident's family member last evening (10/27/14) and family member signed the agreement at that time.	{S5105}		

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 _____	R-C 10/28/2014

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
{S5105}	Continued From page 4 During an interview at 12:00 p.m. on 10/28/14, licensed nurse #A stated resident was at risk for rolling out of bed as the reason staff placed body pillow beside resident and mattress on floor beside resident's bed. Licensed nurse #A confirmed the resident's negotiated service agreement lacked a description of services related to the resident's risk for rolling out of bed, the need for a mechanical soft diet with ground meat with gravy, and that resident would need total assistance to exit the building. The operator failed to ensure the development of a written negotiated service agreement for resident #1020 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, that included a description of services to be provided, the provider of the service.	{S5105}		