STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008007	A. BUILDING: _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MI CASA CARE HOMES LLC	521 MAIN STREET TOWANDA, KS 67144

(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 represent the findings of an initial survey for the above named Home Plus facility conducted on 06/21/23 and 06/22/23.	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) The facility reported a census of two residents with both residents included in the sample. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed on what triggered in the "Functional Capacity Screen" (FCS) for resident (R)101 and R102.	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
	B008007	A. BUILDING: _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MI CASA CARE HOMES LLC	521 MAIN STREET TOWANDA, KS 67144

(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 Findings included: - R101's medical record revealed the resident moved into the facility on 05/01/23. The 05/01/23 FCS identified R101 triggered for bladder incontinence, falls/unsteadiness, impaired vision, impaired hearing, impaired decision-making and inappropriate behavior. The 05/01/23 NSA did not address R101's bladder incontinence, falls/unsteadiness, impaired vision, impaired hearing, impaired decision-making and inappropriate behavior. On 06/22/23 at 12:13 PM Administrative Nurse B acknowledged R101's NSA did not address all that triggered on the FCS. The operator failed to ensure R101's NSA was fully developed to include all items that triggered in the FCS. - R102's medical record revealed the resident moved into the facility on 04/03/23. The 04/03/23 FCS identified R102 triggered for wandering. The 04/03/23 NSA for R102's did not address wandering. On 06/22/23 at 10:55 AM Administrative Nurse B acknowledged the R102's NSA did not address wandering. The operator failed to ensure R102's NSA was	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008007	A. BUILDING: _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MI CASA CARE HOMES LLC	521 MAIN STREET TOWANDA, KS 67144

(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 fully developed to include all items that triggered in the FCS.	S5105		
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 by: KAR 26-42-202(h) The facility had a census of two residents. Both residents were included in the sample. The facility failed to ensure each individual involved in the development of the Negotiated Service Agreement (NSA) signed the agreement for both residents sampled (resident (R)101 and R102.) Findings included: - R101 admitted to the facility on 05/01/23. The 05/01/23 NSA revealed R101 was cognitively impaired and did not include the signature of his legal representative. On 06/22/23 at 12:13 PM Administrative Nurse B acknowledged R101's family member did not sign the NSA.	S5126		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008007	A. BUILDING: _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MI CASA CARE HOMES LLC	521 MAIN STREET TOWANDA, KS 67144

(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
S5126	Continued From page 3 The operator failed to ensure the NSA was signed by the resident's legal representative. - R102 admitted to the facility on 04/03/23. The 04/03/23 NSA revealed R102 was cognitively impaired and did not include the signature of his legal representative. On 06/22/23 at 10:55 AM Administrative Nurse B stated the resident actively participated in the development of the NSA but neither R102 or his legal representative signed it. The operator failed to ensure the NSA was signed by R102 or his resident's legal representative.	S5126		
S5192 SS=E	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations.	S5192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008007	A. BUILDING: _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MI CASA CARE HOMES LLC	521 MAIN STREET TOWANDA, KS 67144

(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
S5192	Continued From page 4 This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (e) The facility had a census of two residents. Both residents ate food prepared in the same kitchen. The operator failed to ensure food items were served at the proper temperature. Findings included: - On 06/21/23 at approximately 03:21PM an observation of the kitchen revealed there was no documentation food temperatures were monitored prior to serving food to the facility residents. On 06/22/23 at approximately 09:37 AM Administrative Nurse B stated staff did not complete food temperature logs. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, hot foods must be maintained at an internal temperature of 135 Fahrenheit (F) or higher and cold foods must be maintained at an internal temperature of 41 F or below. The operator failed to ensure food items were served at the proper temperature.	S5192		
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	S5195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008007	A. BUILDING: _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MI CASA CARE HOMES LLC	521 MAIN STREET TOWANDA, KS 67144

(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
S5195	Continued From page 5 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 had a census of two residents. Both residents ate food prepared in the same kitchen. The operator failed to ensure food items were stored under safe and sanitary conditions by the failure to ensure foods stored in the refrigerators were kept at 41 degrees Fahrenheit (F) or lower according to Food Safety Guidelines. Findings included: - On 06/21/23 at approximately 03:21PM an observation of the kitchen revealed there was no documentation refrigerator or freezer temperatures were completed on a regular basis. On 06/22/23 at approximately 09:37 AM Administrative Nurse B stated staff did not complete refrigerator or freezer logs. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, "Cold foods must be maintained at an internal temperature of 41F or below." "Date mark foods appropriately, cover foods after completely cooled, cover foods to maintain cold holding temperature."	S5195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008007	A. BUILDING: _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MI CASA CARE HOMES LLC	521 MAIN STREET TOWANDA, KS 67144

(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
S5195	Continued From page 6 The operator failed to ensure food items were stored under safe and sanitary conditions by failing to document refrigerator/freezer temperatures.	S5195		
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 26-42-207(c) The facility reported a census of seven residents. Based on interview and record review for three residents and five new employee records, the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105. Findings included:	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008007	A. BUILDING: _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MI CASA CARE HOMES LLC	521 MAIN STREET TOWANDA, KS 67144

(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 7 - Review of five newly hired staff records revealed the following: Certified Medication Aide (CMA) E's employee record revealed a hire date of 04/03/23. The employee provided a TB Skin Test dated 10/24/22 from a former employer. The facility failed to ensure a single TB skin test was started within seven days of employment. Certified Nurse Aide (CNA) F's employee record revealed a hire date of 04/03/23. The facility failed to ensure a TB Symptom Screening Questionnaire was completed within seven days of employment. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident and new employee shall have an initial TB symptom screen that includes the components of the TB symptom questionnaire within seven days of residency or employment ...If a new employee provides satisfactory documentation of receiving a sing TST within 6 months prior to employment that read not positive, the employee shall only be required to have a single TST within 7 days of employment." The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105 regarding newly hired employees. - Resident (R)101 moved into the facility on 05/01/23.	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008007	A. BUILDING: _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MI CASA CARE HOMES LLC	521 MAIN STREET TOWANDA, KS 67144

(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 8 R101's medical record revealed a two-step TST was administered on 01/04/23 and read on 01/06/23. The second step of the two-step TST was administered on 01/09/23 which was four days early and did not provide documentation of this TST being read. On 06/22/23 at 12:13 PM Administrative Nurse B acknowledged the 2nd step of R101's TST was administered early and no date was documented for the reading. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "If the first TST is read as not positive, a second TST shall be administered within 1 to 3 weeks. The second TST shall be read within 48-72 hours of its administration." The administrator failed to ensure compliance with the department's TB guidelines for adult care homes adopted by reference to K.A.R. 26-29-105.	S5230		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff 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	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008007	A. BUILDING: _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MI CASA CARE HOMES LLC	521 MAIN STREET TOWANDA, KS 67144

(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
S5258	Continued From page 9	S5258		

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)(2)

The facility reported a census of two residents. Based on interview and record review, the operator failed to ensure five of five newly hired employee records included evidence the nurse aide certification and a criminal background check was completed prior to staff employment.

Findings included:

- Review of employee files conducted on 06/22/23 revealed the following:
Certified Nurse Aide (CNA) D hired on 04/03/23.
Documentation of a nurse aide registry check was completed on 06/21/23.
Documentation of a Kansas Bureau of Investigation (KBI) check was dated 05/08/23.

CNA E hired on 04/03/23. Documentation of a nurse aide registry check was completed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B008007	A. BUILDING: _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MI CASA CARE HOMES LLC	521 MAIN STREET TOWANDA, KS 67144

(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
S5258	Continued From page 10 05/11/23. Documentation of a Kansas Bureau of Investigation (KBI) background check was dated 05/08/23. CNF F hired on 04/03/23. Documentation of a nurse aide registry check was completed on 06/21/23. Documentation of a KBI background check was dated 05/08/23. CNA G hired on 04/03/23. Documentation of a nurse aide registry check was completed on 06/21/23. Documentation of a KBI background check was dated 05/08/23. CNA H hired on 04/03/23. Documentation of a nurse aide registry check was completed on 05/11/23. Documentation of a KBI background check was dated 05/08/23. The operator failed to ensure nurse aide certification and criminal background checks of newly hired staff were completed prior to staff employment.	S5258		