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 _____	07/23/2024

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

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S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure survey with complaint investigation KS00189340 for the above named Home Plus facility conducted on 07/22/24 and 07/23/24.	S 000		
S5192 SS=F	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. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (e) The facility reported a census of six residents. Based on interview and record review, the operator failed to ensure staff prepared food using safe methods to ensure it was prepared and served at the proper temperatures. Findings included: - Review of the food temperature logs on	S5192		

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

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S5192	Continued From page 1 07/22/24 at 12:39 PM from 04/07/24 revealed a calendar type format that had breakfast, lunch, dinner, and snack spaces for staff to write in what was fixed for the meal and what the temperature was of the food items. The logs from 06/011/24 to 07/22/24 revealed the following: Multiple food items such as soup, cottage cheese, chicken salad, chicken stir fry, chili, cooked vegetables, pot roast, sausage, and chicken were written on the log but did not include a temperature to ensure it was cooked to the proper temperature. The log also failed to have 11 meals with any food items or temperatures. Interview on 07/22/24 at 12:40 PM Certified Medication Aide looked at the food temperature log and acknowledged there were multiple food items without food temperatures and meals with nothing written in it. Review of the "Focus on Food Safety" guide Revised August 2017 provided the following directions for preparing foods: Poultry, stuffed meats, and pastas cooked to 165 degrees Fahrenheit (F). Ground beef or pork cooked to 155 degrees F. The maximum cold temperature is 41 degrees F. The operator failed to ensure designated staff monitored food temperatures to ensure they were prepared to a safe temperature.	S5192		
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	S5215		

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S5215	Continued From page 2	S5215		

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 shall include evacuation of the residents to a secure location.

This REQUIREMENT is not met as evidenced by:
KAR 26-42-104 (d)(3)

The facility reported a census of six residents. Based on record review and interview the operator failed to ensure disaster and emergency preparedness by the failure to conduct quarterly reviews of the home's emergency management plan with all residents and all staff.

Findings included:

- On 07/22/24 at 03:25 PM Administrative Nurse B provided a file folder with training for the Emergency Management Plan (EMP) for all employees which included the following:
Administrative reviewed the EMP on 01/01/24, 04/12/24, and 04/15/24.
Certified Nurse Aide D reviewed the EMP on 01/09/23.
Licensed Nurse E reviewed the training, but the form did not include a date.
In-service for all staff conducted on 04/12/24.

The in-service folder for staff did not include any

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reviews of the EMP for Certified Medication Aide (CMA) F, CMA C, Certified Nurse Aide (CNA) D, CNA G, and CNA I.

The record lacked evidence the EMP was reviewed with all facility staff quarterly.

- Review of the Resident reviews of the Emergency Management Plan (EMP) for facility residents included the following dated for review:
The EMP was reviewed with R3 on 01/01/24 who moved into the facility on 04/03/23.
The EMP was reviewed with R4 on 01/05/24 who moved into the facility on 01/05/24.
The EMP was reviewed with R5 on 04/30/24 who moved into the facility on 04/30/24.
The EMP was reviewed with R6 on 01/01/24 who moved into the facility on 01/01/24.
The EMP was reviewed with R7on 01/24/24 who moved into the facility on 01/23/24.
The EMP was reviewed with R8 on 01/01/24 who moved into the facility on 05/01/23.

The record lacked evidence that the EMP was reviewed quarterly with residents after they moved into the facility.

On 07/22/24 at 03:47 PM Administrative Nurse B reported she did not realize reviewing of the EMP needed to happen quarterly. She stated she would look for records of reviewing the EMP in 2023. Reviewed records of the EMP reviews with her for residents and staff and she said she did not realize it needed to be reviewed every quarter.

On 07/23/24 at 12:11 PM Administrative Nurse reported she was not able to find any reviews of the EMP for 2023.

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S5215	Continued From page 4 The operator failed to ensure disaster and emergency preparedness by the failure to conduct quarterly reviews of the emergency management plan with all residents and staff.	S5215		
S5300 SS=E	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 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)(1) The facility reported a census of six residents (R), with one currently out of the facility. The sample included three residents. Based on interview and record review the operator failed to ensure medications were administered in accordance with a medical care providers written order for two (R3and R4) of three sampled residents. The operator also failed to ensure only a licensed	S5300		

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nurses and medication aides administered and managed medications for three of five residents for which the home was responsible.

Findings included:

- R3's medical record revealed he moved into the facility on 04/03/23 with diagnosis of schizophrenia.

R3's Functional Capacity Screen dated 04/02/24 revealed he was unable to participate in the task of management of his medications.

R3's Negotiated Service Agreement identified Certified Medication Aide and Licensed Nurse would administer medications.

Review of R3's medical providers orders dated 05/12/23 included an order for Haldol (antipsychotic) 1 milligram (mg) twice a day.

Review of R3's July 20242 Medication Administration Record revealed staff administered two 1mg tablets in the evening, and one 1mg table in the morning.

Interview on 07/23/24 at 01:30 PM Administrative Nurse B reviewed R3's record and acknowledged the record did not include a written order for increasing the evening dose of Haldol.

The operator failed to ensure qualified staff administered medications according to a medical providers written order.

- R4's medical record revealed he moved into the facility on 01/05/24 with a diagnosis of Parkinson's disease.

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S5300	Continued From page 6 R4's Functional Capacity Screen dated 01/05/24 identified he was unable to participate in the task of management of his medications or medical treatments. R4's Negotiated Service Agreement dated 01/05/24 revealed Certified Medication Aides or Licensed Nurse would administer all medications. R4's July 2024 Medication Administration Record included the following medications for qualified staff to administer: Carbidopa-Levodopa 25/100 milligrams (mg), give 1.5 tablet four times a day. Miconazole powder twice a day to affected area. Review of R4's current medical providers orders included an order dated 01/05/24 for Carbidopa-Levodopa 10/100 mg. four times a day. It also failed to include an order for Miconazole powder. An interview on 07/23/24 at 11:21 AM Administrative Nurse B looked through R4's chart and acknowledged the record did not include a providers' order for the changes in his Carbidopa-Levodopa or his Miconazole. The operator failed to ensure staff administered medications according to a medical providers written order. - Review of the Resident Roster provided by Administrative Nurse B on 07/22/24 revealed three residents sometimes administered their own medications. An interview on 07/22/24 at 02:29 PM Administrative Nurse B reported there are days when a Certified Nurse Aide (CNA), (someone	S5300		

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S5300	Continued From page 7 who is not qualified to administer medications), is working on day shift and the medications for that day are set up in medication planner by the nurse for the CNA to give to the resident that day. The CNA takes the planner out of the drawer and then hands the planner to the resident to take the medication. On 07/23/24 at 01:46 PM Administrative Nurse B showed the surveyor the July schedule for medication pass which included sixteen days that identified self-administration of medications for the 12:00 PM, 02:00 PM. and the 04:00 PM medication pass times. Review of the medical records the five residents currently in the facility, revealed three of them received medications at 12:00 PM, 02:00 PM, and or 4:00 PM. The operator failed to ensure only a licensed nurse or medication aide administered and managed medications for which the home was responsible.	S5300		
S5301 SS=E	26-42-205 (d) (3) Facility Administration of Medications (d) (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s	S5301		

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medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered.

This REQUIREMENT is not met as evidenced by:
KAR 26-42-205 (d)((3)(D)

The facility reported a census of six residents (R) with one resident out of the facility at this time. The sample included three residents. Based on record review and interview the operator failed to ensure staff administered only medications they had personally prepared and documented that administration immediately before or after completion of the task for three of the five residents/

Findings included:

- An interview on 07/22/24 at 02:29 PM Administrative Nurse B provided the resident roster which identified three residents sometimes self administered their medications. She reported there are days when a Certified Nurse Aide (CNA), (someone who is not qualified to administer medications), is working on day shift and the medications for that day are set up in medication planner for the CNA to give to the resident that day. Administrative Nurse B reported the nurse fills the medication planner and the CNA takes it out of the drawer and gives it to the resident for the resident to open and take. Administrative Nurse B reported the nurse initials on the Medication Administration Record for

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S5301	Continued From page 9 administration of the medication when she sets up the planner. Administrative nurse acknowledged the Nurse prepared the medication planner, initialed for administration of the medication, and then when the medication was due, the CNA took the planner to the resident for them to take the medication. On 07/23/24 at 01:46 PM Administrative Nurse B showed the surveyor the July schedule for medication pass which included sixteen days that identified self-administration of medications for the 12:00 PM, 02:00 PM. and the 04:00 PM medication pass times. Review of the medical records the five residents currently in the facility, revealed three of them received medications at 12:00 PM, 02:00 PM, and/or 4:00 PM. The operator failed to ensure a Licensed Nurse or Certified Medication Aide administered medications they had personally prepared and the documentation of the administration of medications was recorded immediately before or following the completion of the task.	S5301		
S5315 SS=F	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication	S5315		

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S5315	Continued From page 10 room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h)(1) The facility reported a census of six residents. Based on observation and interview, the operator failed to ensure staff stored medications securely to ensure only "Licensed Nurses" and "Medication Aides" had access to the stored medications. Findings included: - Observation on 07/22/24 at 12:08 PM while starting initial tour revealed the medication cart was not locked. Surveyor walked up to the cart	S5315		

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S5315	Continued From page 11 and opened multiple drawers while Certified Medication Aide (CMA) C was in the kitchen preparing lunch. On 07/22/24 at 12:09 PM CMA C reported she had been looking at medications earlier with the physician and just didn't get it locked when finished. On 07/22/24 at 05:01 PM Administrative Nurse B acknowledged the medication cart is supposed to be kept locked unless staff were passing medications. - On 07/22/23 at 01:11 PM Administrative Nurse B reported there is only one staff in the facility for all shifts and sometimes that person is a Certified Nurse Aide (CNA). She reported the medication cart keys are kept in the drawer in the office, which is kept open and accessible to anyone, including the CNA working on that shift. On 07/22/24 at 02:40 PM Administrative Nurse again acknowledged the CNAs have access to the keys, but they know they are not supposed to use them. The operator failed to ensure all medications were stored securely so that only Licensed Nurses and Certified Medication Aides had access to medications.	S5315		