STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089101	A. BUILDING: _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HOMES PLUS	1920 SW 32ND ST TOPEKA, KS 66611

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S 000	INITIAL COMMENTS The following represent the findings of a resurvey for the above named home plus facility conducted on 09/25/24 and 09/26/24.	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 eight residents with three included in the sample. Based on record review and interview the administrator failed to ensure the Negotiated Service Agreements (NSA) for Residents (R)1, R2, and R3 described the services they received based on their Functional Capacity Screens (FCS). Findings included:	S5105		

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

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S5105	Continued From page 1 - Review of R1's record revealed an admission date of 06/16/24 with diagnoses of dementia, depression, urine retention and insomnia. The 06/16/24 FCS identified R1 needed physical assistance with toileting. R1 had difficulty with short term memory, memory/recall, and decision-making. He was identified at risk of falls, wandering, had impaired vision, socially inappropriate disruptive behavior, and impaired decision-making. The 06/16/24 NSA for R1 indicated staff notified nurse of any falls. The NSA failed to identify interventions to prevent falls. The NSA indicated R1 had a suprapubic catheter and failed to mention services provided by staff with catheter. The NSA failed to describe services provided for cognition difficulties, wandering, impaired vision, inappropriate behavior, or decision-making. - Review of R2's record revealed an admission date of 10/09/23 with diagnoses of hearing loss, asthma, hypertension, and peripheral vascular disease. The 09/18/24 FCS identified R2 needed physical assistance with bathing, dressing, and toileting. R2 had bladder incontinence and difficulty with short term memory, memory/recall, and decision-making. She was identified at risk of falls, wandering, had impaired vision, socially inappropriate disruptive behavior, and impaired decision-making. The 09/18/24 NSA indicated staff of one assisted R2 with showers if needed, assisted with any dressing and grooming needs, and one staff assisted with incontinence episodes and perineal care. The NSA failed to identify interventions to	S5105		

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S5105	Continued From page 2 prevent falls and to describe services provided for wandering, impaired vision, inappropriate behavior, or decision-making. - Review of R3's record revealed an admission date of 07/19/24 with diagnoses of Alzheimer's disease, diabetes mellitus type two, insomnia, fibromyalgia, and chronic fatigue. The 07/19/24 FCS identified R3 needed physical assistance with bathing, dressing, toileting, transferring, and was unable to perform walking or mobility. R2 had difficulty with short term memory, memory/recall, and decision-making. She was identified at risk of falls, had impaired vision, socially inappropriate disruptive behavior, and impaired decision-making. The 07/19/24 NSA for R3 indicated staff assisted with showers if needed, assisted with any dressing and grooming needs, assisted with incontinence episodes, and assisted with mobility. The NSA failed to identify interventions to prevent falls and to describe services provided for cognition, impaired vision, inappropriate behavior, or decision-making. On 09/26/24 at approximately 10:18 AM Administrative Staff A confirmed R1, R2, and R3's NSA failed to describe services provided based on their FCS. The operator failed to ensure the NSA for R1, R2, and R3 described the services provided based on their FCS.	S5105		
S5161 SS=F	26-42-204 (d) Health Care Services (d) The negotiated service agreement shall	S5161		

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S5161	Continued From page 3 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 eight residents with three residents included in the sample. Based on interview and record review the operator failed to ensure the resident's Negotiated Service Agreements (NSA) named the licensed nurse responsible for implementing and supervising the plan. Findings included: - Review of R1's record revealed an admission date of 06/16/24 with diagnoses of dementia, depression, urine retention and insomnia. The 06/16/24 Functional Capacity Screen (FCS) identified R1 needed physical assistance with toileting. R1 had difficulty with short term memory, memory/recall, and decision-making. He was identified at risk of falls, wandering, had impaired vision, socially inappropriate disruptive behavior, and impaired decision-making. The 06/16/24 combined NSA and Health Service Plan (HSP) for R1 indicated staff notified nurse of any falls. The NSA/HSP failed to identify interventions to prevent falls. The NSA indicated R1 had a suprapubic catheter and failed to mention services provided by staff with catheter. The NSA/HSP failed to describe services provided for cognition difficulties, wandering,	S5161		

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S5161	Continued From page 4	S5161		

impaired vision, inappropriate behavior, or decision-making.

R1's NSA failed to name the licensed nurse responsible for implementing and supervising his service plan.

- Review of R2's record revealed an admission date of 10/09/23 with diagnoses of hearing loss, asthma, hypertension, and peripheral vascular disease.

The 09/18/24 FCS identified R2 needed physical assistance with bathing, dressing, and toileting. R2 had bladder incontinence and difficulty with short term memory, memory/recall, and decision-making. She was identified at risk of falls, wandering, had impaired vision, socially inappropriate disruptive behavior, and impaired decision-making.

The 09/18/24 combined NSA/HSP indicated staff of one assisted R2 with showers if needed, assisted with any dressing and grooming needs, and one staff assisted with incontinence episodes and perineal care. The NSA/HSP failed to identify interventions to prevent falls and to describe services provided for wandering, impaired vision, inappropriate behavior, or decision-making.

R2's NSA failed to name the licensed nurse responsible for implementing and supervising her service plan.

- Review of R3's record revealed an admission date of 07/19/24 with diagnoses of Alzheimer's disease, diabetes mellitus type two, insomnia, fibromyalgia, and chronic fatigue.

The 07/19/24 FCS identified R3 needed physical

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S5161	Continued From page 5 assistance with bathing, dressing, toileting, transferring, and was unable to perform walking or mobility. R2 had difficulty with short term memory, memory/recall, and decision-making. She was identified at risk of falls, had impaired vision, socially inappropriate disruptive behavior, and impaired decision-making. The 07/19/24 combined NSA/HSP for R3 indicated staff assisted with showers if needed, assisted with any dressing and grooming needs, assisted with incontinence episodes and assisted with mobility. The NSA/HSP failed to identify interventions to prevent falls and to describe services provided for cognition, impaired vision, inappropriate behavior, or decision-making. R3's NSA failed to name the licensed nurse responsible for implementing and supervising her service plan. On 09/26/24 at 10:14 AM Administrative Staff A confirmed R1, R2 and R3s NSAs failed to specifically state who the nurse responsible for implementing and supervising the service plans should have been. She confirmed that all residents' NSAs are the same with only the nurse signature line on the last page of each NSA. The operator failed to ensure the residents' NSAs named the licensed nurse responsible for implementing and supervising the service plans for all residents.	S5161		
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	S5230		

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S5230	Continued From page 6	S5230		

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 eight residents with three residents included in the sample and five employee records. Based on interview and record review the operator 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 for Residents (R) 1, R3, Certified Nurse Aide (CNA) D and Certified Medication Aide (CMA) E which potentially affects all residents.

Findings included:

- Record review for R1 revealed an admission date of 06/16/24. His first step of tuberculosis skin testing (TST) was started on 06/16/24 with the second step administered 07/19/24, over four weeks later.

Record review for R3 revealed an admission date of 07/19/24. Her first step of tuberculosis skin

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S5230	Continued From page 7 testing was started on 07/19/24 with the second step administered 09/19/24, over four weeks later. Record review for CNA D revealed a hire date of 06/06/23. Her first step of tuberculosis skin testing was started on 06/18/23 with the second step administered 08/04/23, over eight weeks later. Record review for CMA E revealed a hire date of 05/30/23. CMA E provided a two-step tuberculosis skin test from prior employment dated June of 2022. Her record lacked evidence of documentation of TB testing and symptom screening completed upon hire. On 09/26/24 at approximately 01:17 PM Administrative Staff A confirmed R1, R2 and CMA D tests were done late and no testing was done for CMA E on hire. The department's June 2013 "Tuberculosis (TB) Guideline for Adult Care Homes" documented each new resident and employee shall receive a two-step TST with the second TST administered within one to three weeks. If a new employee provides satisfactory documentation of a single TST within six months prior to employment, the employee shall only be required to have a single TST. The facility's policy titled "Tuberculosis Testing - Mantoux - PPD" dated 12/01/20 failed to state timeframes for testing. 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, which had the	S5230		

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S5230	Continued From page 8 potential to affect all residents.	S5230		
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 the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(3) The facility reported a census of eight residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full names of the residents on the original packages of three over-the-counter (OTC) medications. Findings included: - Observation on 09/25/24 at 10:06 AM revealed Certified Medication Aide B unlocked and opened the medication cart where the medications for the residents were stored. The following over-the-counter medications were not labeled with residents' full names:	S5313		

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S5313	Continued From page 9 One tube hydrocortisone cream 1%, one ounce One bottle loperamide hydrochloride 1 milligram per 7.5 milliliter, 8 fluid ounces Polyethylene glycol 3350, 510 grams On 09/25/24 at approximately 10:08 AM Certified Medication Aide B confirmed the OTC medications were not labeled with residents' full names. The facility's "Medication - Pharmacy Policy" dated 12/01/20 failed to address labeling of over-the-counter medications. The operator failed to ensure all OTC medications were labeled with the residents' full names.	S5313		