STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089043	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDLAND CARE RESIDENTIAL CENTER	120 SW FRAZIER CIRCLE TOPEKA, KS 66606

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S 000	INITIAL COMMENTS The following represent the findings of a resurvey for the above named Residential Health Care facility conducted on 02/05/25, 02/06/25.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility 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: 3085 KAR 26-41-202(a)(1) The facility reported a census of 13 residents with three residents included in the sample. Based on observation, interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) was fully	S3085		

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

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S3085	Continued From page 1 developed based on the resident's "Functional Capacity Screen" (FCS), service needs, and preferences for resident (R)102 and R103. Findings included: - R101's medical record revealed he moved into the facility on 10/23/23 with a diagnosis of dementia. The 12/23/23 FCS identified R101 was independent with transfers and mobility and was at risk for falls. The 12/23/23 NSA did not identify that R101 used a bed assist device for transfers and did not address falls. An observation on 02/06/25 at 08:35 AM revealed R101 was alert and oriented and was independent with transfers and ambulation using a two-wheeled walker. R101's bed had bilateral quarter rails properly installed. On 02/06/25 at 01:32 PM "Licensed Nurse" (LN) B stated R101's NSA did not address the use of a bed rail and did not address what services staff provided concerning falls. The operator failed to ensure R101's NSA was fully developed to include all items that triggered on the FCS, his service needs, and preferences. - R103's medical record revealed she moved into the facility on 08/12/24 with a diagnosis of diabetes mellitus.	S3085		

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S3085	Continued From page 2 The 12/23/24 FCS identified R103 was at risk for falls. The 12/23/24 NSA did not identify that R103 used a bed assist device for transfers and did not address falls. An observation on 02/06/25 at 01:08 PM revealed R103 was alert and oriented. She sat in her wheelchair, wore proper footwear and had bilateral quarter rails properly installed on her bed. On 02/06/25 at 01:59 PM LN B stated R103's NSA did not address the use of a bed rail and did not address what services staff provided concerning falls. The operator failed to ensure R103's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences.	S3085		
S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications.	S3186		

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S3186	Continued From page 3 This REQUIREMENT is not met as evidenced by: 3186 KAR 26-41-205(b) The facility reported a census of 13 residents. The sample included three residents. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for resident (R)102 identified the responsible person for administration and management of selected medications. Findings included: -R102's medical record revealed she moved into the facility on 04/05/24 with a diagnosis of diabetes mellitus. The 12/23/24 "Functional Capacity Screen" (FCS) identified R102 required physical assistance with management of medications. The 12/23/24 NSA identified staff administered R102's medications but did not identify that she self-administered select medications. On 02/06/25 at 10:00 AM stated she self-injected her own insulin and staff administered all of her other medications. On 02/06/25 at 01:53 PM "Licensed Nurse" (LN) B stated R102's NSA did not identify which select medications she self-administered. The operator failed to ensure the NSA identified who was responsible for administration and	S3186		

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S3186	Continued From page 4 management of select medications for R102.	S3186		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (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: 3211 KAR 26-41-205 (g)(3) The facility reported a census of 13 residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of some over the counter (OTC) medications. Findings included: - Observation on 02/05/25 at 03:00 PM of the medication cart revealed the following OTC	S3211		

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S3211	Continued From page 5 medications not labelled with the full name of the resident: Resident (R)104: One bottle of Human-n Super Beets One container of CBNIGHT Gummies The following items were not labelled with the full name of a resident: One tube of Medline Remedy Antifungal Ointment One container of Medline Remedy Antifungal Powder The 07/2024 "Medications Administration" policy documented, "Over-the-counter medications will state the full name of the resident on the container." The operator failed to ensure all OTC medications were labeled by a pharmacist or licensed nurse with the resident's full name.	S3211		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene	S3305		

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S3305	Continued From page 6 meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (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; and (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: 3305 KAR 26-41-207(b)(4) The facility had a census of 13 residents. All 13 residents ate food prepared in the same kitchen. The operator failed to ensure sanitary conditions for food service by not ensuring hot water temperature and chemical strengths were documented daily. Findings included:	S3305		

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S3305	Continued From page 7 An observation of the main kitchen on 02/05/25 at 03:42 PM revealed the following: A temperature log for February 2025 contained documentation for the dishwasher had hot water temperatures that ranged between 124-129 degrees Fahrenheit. The dishwashing machine was identified as a low-temperature system that relied on chemicals for sanitization of dishes. A container of chlorine test strips were located in the top drawer of an island nearest the dishwasher. An interview on 02/05/25 at 03:45 PM with Dietary Staff C revealed staff monitored hot water temperatures for the dishwasher but did not monitor the chemical strength. Review of the "Machine Ware Washing" policy documented, "Monitor wash and rinse temperature of the dish machine and chemical sanitizer during each major use (2 times daily) ...Chlorine Sanitizer- 50 parts per million (PPM)." The operator failed to ensure sanitary conditions in the kitchen by failing to ensure documentation of chemical sanitizer strength was logged daily.	S3305		
S3310 SS=D	26-41-207 (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	S3310		

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S3310	Continued From page 8 employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' 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: 3310 KAR 26-41-207(c) The facility reported a census of 13 residents. Based on record review and interview the operator failed to ensure the facility was in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings include: - Resident (R)102 admitted to the facility on 04/05/24 with a diagnosis of diabetes mellitus. Review of R102's medical records revealed she did not have the first step of a two-step TB skin test (TST) completed upon admission to the facility, but instead had it administered approximately one month later. On 02/06/25 at 01:53 PM "Licensed Nurse" (LN) B acknowledged the first step of the two-step TB skin test was not administered within seven days of admission.	S3310		

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S3310	Continued From page 9 The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of residency ..." The operator failed to ensure the compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		