STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046054	A. BUILDING: _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

(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 citations represent the findings of the licensure resurvey with complaint numbers 174462, 174463, 173752, and 171792 for the above named facility conducted on 09/26/22, 09/27/22 and 09/28/22.	S 000		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (a) The facility reported a census of 71 residents. The sample included five resident's (R's) and 1 closed record review. Based on interview and record review the administrator failed to ensure the "Functional Capacity Screen" (FCS) for R112 was completed and identified R112 having impaired cognitive status at or prior to the time of	S3080		

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
	N046054	A. BUILDING: _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

(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
S3080	Continued From page 1 admission to the locked memory care unit. - Record review on 09/27/22 for R 112 revealed an admission date of 08/29/22 to the with diagnoses of dementia, anxiety, major depressive disorder, panic disorder, and altered mental status. Review of R112 "Functional Capacity Screen" (FCS) dated 08/23/2022 identified R 112 required supervision with bathing, and she required physical assistance with dressing. She was independent with toileting, transferring, walking, and eating. She lacked the ability to manage her own medications, and she was usually continent. The record lacked scores for her cognition. She was able to make herself understood and she was able to understand others. She was marked as a risk for wandering and she had impaired decision making. Review of R112 combined "Negotiated Service Agreement" (NSA) /" Health Care Service Plan" (HSP) instructed facility staff to provide stand by assist for bathing, provide occasional assistance with zippers, shoes and stockings. R112 NSA /HSP lacked instruction to facility staff on management of wandering behaviors and assistance with making appropriate decisions. Interview on 09/27/22 with R112 revealed resident was talking with staff and had difficulty with finding words. She would repeat herself and voiced concern because she had not heard from her family. R112 would repeat things several times and would refer to the same incidents throughout the conversation.	S3080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046054	A. BUILDING: _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

(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
S3080	Continued From page 2 Interview on 09/28/22 with administrator B, he confirmed cognition section of R112 FCS lacked any documentation of cognitive impairment for R112 who resided in a locked memory care unit. The administrator failed to ensure the "Functional Capacity Screen" (FCS) for R112 was completed and identified R112 having impaired cognitive status at or prior to the time of admission to the locked memory care unit.	S3080		
S3085 SS=D	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: K.A.R. 26-41-202 (a)	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046054	A. BUILDING: _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

(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
S3085	Continued From page 3	S3085		

The facility reported a census of 71 residents. The sample included five resident's (R's) and one closed record review. Based on interview and record review the administrator failed to ensure the combined "Negotiated Service Agreement" (NSA)/" Health Care Service Plan" (HSP) provided a description of services required for R112, who was identified as having impaired cognitive status from her medical provider on 08/29/22, and prior to the time of admission to the locked memory care unit.

- Record review on 09/27/22 for R 112 revealed an admission date of 08/29/22 to the with diagnoses of dementia, anxiety, major depressive disorder, panic disorder, and altered mental status.

Review of R112 "Functional Capacity Screen" (FCS) dated 08/23/2022 identified R 112 required supervision with bathing, and she required physical assistance with dressing. She was independent with toileting, transferring, walking, and eating. She lacked the ability to manage her own medications, and she was usually continent. The record lacked scores for her cognition. She was able to make herself understood and she was able to understand others. She was marked as a risk for wandering and she had impaired decision making.

Review of R112 combined "Negotiated Service Agreement" (NSA) /" Health Care Service Plan" (HSP) instructed facility staff to provide stand by assist for bathing, provide occasional assistance with zippers, shoes and stockings. R112 NSA /HSP lacked instruction to facility staff on management of wandering behaviors and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046054	A. BUILDING: _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

(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
S3085	Continued From page 4	S3085		

assistance with making appropriate decisions. The document included a "Mini Mental Questionnaire" which lacked documentation. The document further included a section titled "Mentation, Socialization and Behavior Assessment / Review"; this section lacked any documentation.

Record review of R112 "History and Physical" performed on 08/29/22 revealed the resident had clear and lucid cognition and was orientated to self. She had a normal mood and affect, she was pleasant and cooperative with some forgetfulness, confusion and dementia. The assessment and plan portion of the document identified the resident had increased confusion and paranoia, and she was found to have a left temporoparietal mass. A craniotome was performed on 08/09/22 for a malignant tumor resection.

Interview on 09/27/22 with R112 revealed resident was talking with staff and had difficulty with finding words. She would repeat herself and voiced concern because she had not heard from her family. R112 would repeat things several times and would refer to the same incidents throughout the conversation.

Interview on 09/28/22 with administrator B, he confirmed the combined NSA/HSP lacked cognition section of R112 FCS lacked any documentation of cognitive impairment for R112 who resided in a locked memory care unit.

The administrator failed to ensure the combined "Negotiated Service Agreement" (NSA)/" Health Care Service Plan" (HSP) provided a description

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046054	A. BUILDING: _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

(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
S3085	Continued From page 5 of services required for R112, who was identified as having impaired cognitive status from her medical provider on 08/29/22, and prior to the time of admission to the locked memory care unit.	S3085		
S3165 SS=F	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall 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: K.A.R. 26-41-204 (d) The facility reported a censes of 71 residents. The sample included five "residents" (R's) and one closed record review. Based on record review and interview the administrator failed to ensure the "Negotiated Service Agreement" (NSA) contained the name of the "Licensed Nurse" (LN) responsible for the supervision and implementation of the "Health Care Service Plan" (HSP) for four (R112, R116, R 118 and R120) of the five sampled residents. Findings included: - Record review on 09/27/22 for R 112 revealed an admission date of 08/29/22 with diagnoses of dementia, anxiety, major depressive disorder, panic disorder, and altered mental status.	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046054	A. BUILDING: _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

(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
S3165	Continued From page 6	S3165		

Review of R112 "Functional Capacity Screen" (FCS) dated 08/23/2022 identified R 112 required supervision with bathing, and she required physical assistance with dressing. She was independent with toileting, transferring, walking, and eating. She lacked the ability to manage her own medications, and she was usually continent. The record lacked scores for her cognition. She was able to make herself understood and she was able to understand others. She was marked as a risk for wandering and she had impaired decision making.

Review of R112 combined "Negotiated Service Agreement" (NSA) /" Health Care Service Plan" (HSP) instructed facility staff to provide stand by assist for bathing, provide occasional assistance with zippers, shoes and stockings. R112 NSA /HSP lacked instruction to facility staff on management of wandering behaviors and assistance with making appropriate decisions. The combined NSA/HSP further lacked the name of the licensed nurse responsible for the implementation and supervision of the HSP.

- Record review for R116 revealed an admission date of 06/24/2022 with diagnoses of chronic kidney disease stage three, cancer, diabetes type 2, injury of head, atrial fibrillation edema, acute diastolic heart failure, and edema.

Review of R116 FCS identified he required physical assistance with bathing, dressing, toileting, transferring, and he required supervision with walking/mobility. He lacked the ability to manage his own medications, he was marked having a urinary catheter, and he had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046054	A. BUILDING: _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

(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
S3165	Continued From page 7	S3165		

impaired decision making. He was able to make himself understood and he understood others. He was marked with falls, and he used a walker and wheelchair mobility devices.

Review of R116 NSA/HSP instructed facility staff to provide assistance with bathing, transfers, dressing, toileting and general health management. He would require assistance with the urinary catheter. The document stated the facility "will provide a nurse to oversee medical care". The document lacked the name of the licensed nurse responsible for the implementation and supervision of the HSP.

- Record Review for R118 revealed a re-admission date of 05/17/22 with diagnoses of unspecified atrial fibrillation, chronic respiratory failure, other specified anxiety disorders, history of falls, Raynaud's syndrome, peripheral vascular disease, and anemia.

Review of R118 FCS dated 05/17/22 identified she required supervision with bathing, and dressing, transferring, walking and mobility. She required physical assistance with toileting. She required supervision with medication management and was usually continent. Her cognition was intact, and she was able to make herself understood and she understood others. She was marked with falls and impaired vision. She used a walker and wheelchair mobility devices.

Review of R118 NSA/HSP dated 05/17/22 instructed facility staff to provide stand by assist with ambulation and all activities of daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046054	A. BUILDING: _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

(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
S3165	Continued From page 8 The document stated the facility will "provide a primary care nurse and will coordinate medical care". The document lacked the name of the licensed nurse responsible for the implementation and supervision of the HSP. - Record review R120 revealed an admission date of 06/29/2022 with diagnoses of essential primary hypertension, patient's noncompliance with other medical treatment and regimen, unspecified osteoarthritis, hyperlipidemia, primary osteoarthritis of bilateral hands, localized edema, hyperglycemia, cardiac murmur, and other amnesia. Review of R120 FCS dated 08/08/2022 identified she was independent with bathing, dressing, toileting, transferring, walking, and eating. She lacked the ability to manage her own medications, and she was usually continent. She had impaired short - term memory, impaired memory recall, and impaired decision making. She was usually able to make herself understood and she usually understood others. She was marked with wandering and impaired decision making. She used a walker mobility device. Review of R120 NSA/HSP instructed facility staff to provide assistance with bathing, grooming, dressing and manage her medications. She would require regular monitoring of her transfers and ambulation. The document stated an assisted living nurse will over see medical care. The document lacked the name of the licensed nurse responsible for the implementation and supervision of the HSP.	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046054	A. BUILDING: _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

(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
S3165	Continued From page 9 Interview on 09/28/22 with administrator B confirmed the NSA's for R112, R116, R118, and R120 lacked the name of the nurse responsible for the implementation and supervision the health care service plan. The administrator failed to ensure the "Negotiated Service Agreement" (NSA) contained the name of the "Licensed Nurse" (LN) responsible for the supervision and implementation of the "Health Care Service Plan" (HSP) for R112, R116, R 118 and R120.	S3165		
S3248 SS=D	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (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 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 care home; 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	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046054	A. BUILDING: _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

(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
S3248	Continued From page 10 have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-102 (d) (3) The facility reported a census of 71 residents. The sample included six residents and 5 newly hired employees. Based on record review and interview the administrator failed to ensure the facility had supporting documentation from the Kansas nurse aide registry that newly hired employee "Certified Medication Aide" (CMA) A did not have a finding of abused, neglected or exploited a resident in an adult care home. Findings included: - Record review of facility provided employee records on 09/27/22 of newly hired CMA A revealed a hire date of 07/29/22. The provided documents lacked a document from the Kansas nurse aide registry showing CMA A did not have a finding of abused, neglected or exploited a resident in an adult care home. . Interview on 09/28/22 with administrator B, he confirmed the documents provided lacked the required document from the Kansas nurse aide registry for CMA A. The administrator failed to ensure the facility had supporting documentation from the Kansas nurse aide registry that newly hired employee "Certified	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046054	A. BUILDING: _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

(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
S3248	Continued From page 11 Medication Aide" (CMA) A did not have a finding of abused, neglected or exploited a resident in an adult care home.	S3248		
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 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: K.A.R. 26-41-207 (c) The facility reported a census of 71 residents. The sample included five residents (R's), one closed record review and five newly hired employees. Based on record review and interview 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 K.A.R. 26-39-105 for R112, and newly hired personnel "Certified Medication Aide" (CMA) A, "Licensed	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046054	A. BUILDING: _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

(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
S3310	Continued From page 12	S3310		

Nurse" (LN) C, and "Certified Nurse Aide" (CNA) D.

Findings included:

- Record review on 09/27/22 of newly hired CMA A revealed she began employment on 02/29/22. The employee record lacked documentation of the required first step of the two step TB test being administered within seven days of employment. The record further lacked the documentation for the required second step of the two step TB test being administered one to three weeks after the completed first step.

Record review of newly hired LN C revealed she began employment on 03/29/22. The employee record contained a document revealing the first step of the two step TB test was implanted on 04/04/22. The record lacked an entry for a read/completed date. The record further lacked the documentation for the required second step of the two step TB test being administered one to three weeks after the completed first step.

Record review of newly hired CNA D revealed he began employment on 04/12/22. The employee record lacked documentation of the required first step of the two step TB test being administered within seven days of employment. The record further lacked the documentation for the required second step of the two step TB test being administered one to three weeks after the completed first step.

Record review for R 112 revealed an admission date of 08/29/22 with diagnoses of dementia, anxiety, major depressive disorder, panic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046054	A. BUILDING: _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

(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
S3310	Continued From page 13 disorder, and altered mental status. The record included the first step of the required two step TB test was implanted on 08/30/22 and read negative on 09/02/22. The record lacked the administration of the required second step within one to three weeks after the date of admission. Interviw on 09/28/22 with administrator B, he confirmed the employee and resident records for CMA A, LN C, CNA D, and R 112 lacked the required documentation for the required two step TB test being perfomed one to seven days after employement / admission, and the required second step being performed one to three weeks after the completed first step. 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 K.A.R. 26-39-105 for R112, and newly hired personnel "Certified Medication Aide" (CMA) A, "Licensed Nurse" (LN) C, and "Certified Nurse Aide" (CNA) D.	S3310		