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 _____	02/08/2024

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 represent the findings of a resurvey for the above named assisted living conducted on 02/07/24 and 02/08/24.	S 000		
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: KAR 26-41-202(a)(1)(2) The facility reported a census of 71 residents with six residents included in the sample. Based on observation, interview and record review the administrator failed to ensure the "Negotiated Service Agreements" (NSA) for Residents (R) 3 and R6 described the services they received	S3085		

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 _____	02/08/2024

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 1 based on their "Functional Capacity Screens" (FCS). Findings included: - Record review for R4 revealed an admission date of 06/22/22 with diagnoses of type two diabetes mellitus and urinary catheter. The 11/28/23 "FCS" identified R3 required physical assistance with toileting and was independent with transfers. The 04/11/23 "NSA" identified R3 was independent with transfers. Facility staff would empty his urinary catheter bag daily and home health was responsible for catheter changes. The "NSA" failed to identify R4 used a bed assist device for assistance to transfer independently from bed to his wheelchair. Observation on 02/08/24 at approximately 11:18 AM revealed a bed rail was attached to the left side of R3's bed. On 02/08/24 at approximately 11:18 AM R3 stated he used the bed rail to help him move from his bed to his wheelchair. On 02/08/24 at 11:05 AM during phone interview Administrative Nurse G stated R3 was provided daily dressing changes to his suprapubic catheter site by a licensed nurse. She confirmed the service was not described on his "NSA." On 02/08/24 at 11:26 AM Administrative Nurse G confirmed R3 used his bed rail to transfer from bed.	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 _____	02/08/2024

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 2 - Record review for R6 revealed an admission date of 02/15/23 with a diagnosis of dementia. The 01/20/24 "FCS" identified R6 had short-term and long-term memory, memory recall, and decision-making cognitive difficulties and was rarely or never understandable and rarely or never understood others during communication. The 12/12/23 "NSA" failed to identify the services provided R6 for cognitive difficulties and communication. On 02/08/24 at approximately 09:44 AM Administrative Nurse F confirmed R6's "NSA" failed to describe the services provided for cognitive difficulties and communication. The administrator failed to ensure the "NSAs" for R3 and R6 described the services they received based on their "FCS."	S3085		
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.	S3211		

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 _____	02/08/2024

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
S3211	Continued From page 3 This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 48 residents in the assisted living and 23 in the memory care. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of eight over-the-counter (OTC) medications in the assisted living. Findings included: - Observation on 02/07/24 at 09:46 AM revealed Certified Medication Aide (CMA) D unlocked and opened the second-floor assisted living medication cart. The following OTC medications were not labeled with residents' full names: One bottle of vitamin D3 extra strength, 60 gummies One bottle of calcium with D3 500 milligrams (mg), 80 gummies One bottle of Centrum Silver Women 50+ tablets One bottle of Osteo Bi-Flex joint health 200 tablets On 02/07/24 at approximately 09:46 AM CMA D confirmed four OTC medications on the second-floor assisted living medication cart were not labeled with residents' full names. Observation on 02/07/24 at 10:10 PM revealed CMA E unlocked and opened the first-floor	S3211		

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 _____	02/08/2024

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
S3211	Continued From page 4 assisted living medication cart. The following OTC medications were not labeled with residents' full names: One bottle of acetaminophen 500 mg, 225 caplets One bottle of acetaminophen 500 mg, 150 caplets One bottle of antacid tablets 66 tablets One bottle of vit D3 extra strength, 60 gummies On 02/07/24 at approximately 10:10 PM CMA E confirmed four OTC medications on the first-floor assisted living medication cart were not labeled with residents' full names. The 09/10/19 facility's "Over the Counter Medications" policy documented a licensed nurse shall place the full name of the resident on the original manufactuer's medication package and the medication container. The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of eight OTC medications.	S3211		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (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 employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency	S3280		

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 _____	02/08/2024

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
S3280	Continued From page 5 procedures; (3) quarterly review of the facility ' 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 26-41-104(d)(3) The facility reported a census of 71 residents. Based on interview and record review the administrator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan with staff and residents were completed. Findings included: - Review of the facility's emergency plan records lacked evidence of documentation quarterly reviews were completed with staff during the fourth quarter of 2023 and with residents for all quarters of 2023. On 02/08/24 at approximately 12:07 PM Administrative Staff A confirmed the facility's record lacked documentation reviews of the emergency management plan were completed quarterly with staff and residents. The 04/20/22 facility's "Emergency	S3280		

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 _____	02/08/2024

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
S3280	Continued From page 6 Preparedness" policy documented the emergency preparedness plan would be reviewed quarterly with staff and residents. The administrator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan with staff and residents were completed.	S3280		
S3310 SS=F	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: KAR 26-41-207(c) The facility reported a census of 71 residents with six residents included in the sample. Based on interview and record review the administrator failed to ensure the facility remained in compliance with the department's tuberculosis	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 _____	02/08/2024

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 7 (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for three residents. Findings included: - Record review for Resident (R) 1 revealed an admission date of 04/07/23 with a diagnosis of type 2 diabetes mellitus. The 04/07/23 step one of the two-step TB skin test for R1 was negative. Her record lacked evidence of documentation of the second step. On 02/07/24 at 01:12 PM Administrative Nurse G confirmed R1's record lacked evidence of documentation of a second TB skin test. Record review for R2 revealed an admission date of 01/19/23 with a diagnosis of Alzheimer's disease. The 01/26/23 step one of the two-step TB skin test for R2 was negative. Her record lacked evidence of documentation of the second step. On 02/07/24 at 03:21 PM Administrative Nurse G confirmed R2's record lacked evidence of documentation of a second TB skin test. Record review for R4 revealed an admission date of 02/06/19 with unidentified diagnoses. The 08/27/20 TB symptom screen questionnaire for R4 was negative. Her record lacked evidence of documentation of annual symptom screens since 08/27/20 which was three years and 164 days at the time of the survey.	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 _____	02/08/2024

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 8 On 02/08/24 at approximately 10:43 AM Administrative Nurse G confirmed R4's most recent TB symptom screen questionnaire was 08/27/20. The facility's 05/14/20 "Residents Screening for Tuberculosis" policy documented testing would be performed on each new resident within one week following admission and could include the two-step method. All residents would have an "Annual Tuberculosis Symptom Review Questionnaire" completed annually. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new resident shall receive a two-step TB skin test within seven days of admission. The administrator 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.	S3310		