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	175466	A. BUILDING _____ B. WING _____	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT WICHITA, LLC	1315 N WEST STREET WICHITA, KS 67203

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent Health Resurvey 8F3011 and Complaint investigations KS00146876, KS00162057, KS00163490	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The facility census totaled 58 residents, with 15 residents in the sample. Based on observation, interview, and record review, the facility failed to treat Resident (R) 9 with dignity and respect when a Certified Nurse Aid (CNA) used her personal phone, scrolled on personal social media, but did not engage with the resident she assisted with eating during dinner service. Findings included: - Observation of dining on 07/20/21 at 08:41 AM revealed CNA D at the assisted table playing/scrolling on her personal phone instead of engaging/feeding/cueing cognitive R9. Interview with CNA D on 07/20/21 at 08:45 AM revealed she stated, "she worked night shift usually, but staff was not supposed to have their phones out when providing assistance with feeding." Interview with Administrative Nurse B on 07/20/21 at 08:46 AM revealed she expected that the staff's phones should not be out when providing any resident care; eating, dressing, toileting, etc. Interview during resident council on 07/21/21 at 02:30 PM revealed R167 stated, "the staff used	F 550		

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F 550	Continued From page 2 their personal phones all the time when caring/around the residents." Interview with R9 on 07/22/21 at 05:40 PM revealed she stated, "she did not like the staff using/playing on their phones when they were feeding her because it is rude." The facility failed to provide a policy regarding dignity as requested on 07/22/21. The facility failed to treat R9 with dignity and respect when CNA D used her personal phone, scrolled on personal social media, but did not engage with the resident she assisted with eating during dinner service.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		

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F 578	Continued From page 3 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: The facility census totaled 58 residents, with 15 residents in the sample. Based on observation, interview, and record review, the facility failed to ensure that Residents (R) 47 and R267 had Advanced Directives/Code Status noted on the physical chart or on the Electronic Medical Record (EMR), which could have resulted in a resident receiving Cardiopulmonary Resuscitation (CPR) in the event of resident demise instead of the Do Not Resuscitate (DNR) as requested. Findings included: - Review of R47's pertinent diagnoses from "Physician's Orders" for diagnosis in the "Electronic Medical Record (EMR)" dated 05/19/21 revealed Parkinson's disease (a slowly	F 578		

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progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), Chronic Kidney Disease (CKD- a condition characterized by a gradual loss of kidney function over time), and Atherosclerotic Heart Disease (a condition which affects the arteries that supply the heart with blood; a buildup of plaque inside the artery walls).

Review of the 06/02/21 "Admission Minimum Data Set" (MDS) revealed a Brief Interview for Mental Status (BIMS) of 14, indicating intact cognition.

Review of 05/21/21 "Care Plan" revealed the care plan lacked Advanced Directives/Code Status.

Review of 05/21/21 at 10:27 AM "Social Services Clinical Note" revealed Social Services M met with the newly admitted resident and completed initial paperwork with him.

Review of R47s physical chart and EMR on 07/20/21 at 11:17 AM for Advanced Directives revealed both lacked documentation for Advanced Directives/Code Status.

Observation of R47 on 07/22/21 at 01:22 PM revealed the resident in the therapy room completing therapy.

Interview with R47 on 07/20/21 at 09:46 AM revealed he has a DNR on file, and he expected the facility to follow his wishes.

Interview with Certified Nurse Aide (CNA) E on 07/21/21 at 01:13 PM revealed she did not know R47s code status, but stated, "if the resident is a

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DNR, there is a signed DNR very first thing on the chart in a red pocket in the front and also noted on the EMR."

Interview with CNA O on 07/21/21 at 01:46 PM revealed she did not know the resident's code status but stated: "it should be noted on the face sheet in the chart." She continued, "if she found him unresponsive, she would get the nurse and find out the code status, and if the information was not there, she would start CPR."

Interview with Licensed Nurse (LN) P on 07/20/21 at 11:17 AM revealed the Advanced Directives should be documented on the physical chart with the signed paperwork and the EMR in the section named "Advanced Directives" under resident info. She continued, "right now, staff would treat him as a full code since the facility has no documentation for Advanced Directives."

Interview with LN K on 07/21/21 at 11:02 AM revealed she did not know what his Advanced Directives/Code Status was, but stated, "his code status should be on his face sheet or under the Advanced Directives tab in his physical chart and EMR chart." She then obtained the resident's physical chart and looked at his EMR chart and validated that the resident's Advanced Directives were not clear. She then stated, "she would not know where it is then because the physical chart and EMR was where the information should be, and the admitting nurse should have gotten all of that information."

Interview with Administrative Nurse B on 07/22/21 at 10:00 AM revealed the expectation for Advanced Directives/Code Status was the facility obtained the information/documentation on

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admission, and the documentation should be on the physical chart and in the EMR under Advanced Directives.

Interview with Administrative Staff A on 07/22/21 at 11:11 AM revealed the business office had an Advanced Directive/Code Status for a DNR for R47 signed on 05/20/21 by the resident, so she will update his EMR and physical chart with that information.

Review of undated "Advanced Directives" policy revealed every resident would be asked on admission if [they] have executed an advanced directive. If the resident has an advanced directive, a copy will become part of the resident's record.

The facility failed to ensure that R47 had Advanced Directives noted on the physical chart or on the EMR, which could have resulted in a resident receiving CPR in the event of resident demise instead of the DNR as requested.

- Review of R 267's pertinent diagnoses from "Physician's Orders" for diagnosis in the "Electronic Medical Record (EMR)" dated 06/23/21 revealed Dementia (a progressive mental disorder characterized by failing memory, confusion), Chronic Obstructive Pulmonary Disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and Chronic Kidney Disease (CKD- a condition characterized by a gradual loss of kidney function over time).

Review of 07/14/21 "Baseline Care Plan" revealed the care plan lacked Advanced

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F 578	Continued From page 7 Directives/Code Status. Review of R267s "EMR" on 07/20/21 at 01:21 PM revealed no Advanced Directives/Code Status noted. Observation of R267 on 07/20/21 at 01:08 PM revealed the resident had returned from an emergency room (ER) visit with marked bruising/hematoma surrounding the right eye from a fall earlier in the morning. Observation/review of R267s physical chart created on 07/21/21 at 11:38 AM revealed a "Transportable Physicians Orders for Patient Preferences (TPOPP)" dated 02/27/20 that noted the resident's Code Status as a DNR. Interview with Licensed Nurse (LN) Q on 07/20/21 at 01:21 PM revealed he could not find the residents physical chart, and his Advanced Directives/Code Status was not documented as it should be on the EMR so that the resident would be treated as a "Full Code" and get CPR. Interview with LN P on 07/20/21 at 01:21 PM revealed she could not find the resident's physical chart and his Advanced Directives/Code Status was not documented as it should be on the EMR so that the resident would be treated as a "Full Code" and get CPR. Interview with Certified Nurse Aide (CNA) E on 07/21/21 at 01:13 PM revealed she did not know his code status, but stated, "if the resident is a DNR, there is a signed DNR very first thing on the chart in a red pocket in the front and also noted on the EMR."	F 578		

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Interview with CNA O on 07/21/21 at 01:46 PM revealed she did not know the resident's code status but stated: "it should be noted on the face sheet in the chart." She continued, "if she found him unresponsive, she would get the nurse and find out the code status, and if the information was not there, she would start CPR."

Interview with LN K on 07/21/21 at 11:02 AM revealed she did not know what his Advanced Directives/Code Status was, but stated, "his code status should be on his face sheet or under the Advanced Directives tab in his physical chart and EMR chart, she would not know where the information was because the physical chart and EMR was where the information should be, and the admitting nurse should have gotten all of that information."

Interview with Administrative Nurse B on 07/22/21 at 10:00 AM revealed the expectation for Advanced Directives/Code Status was the facility obtained the information/documentation on admission, and the documentation should be on the physical chart and in the EMR under Advanced Directives.

Review of the undated "Advanced Directives" policy revealed every resident would be asked on admission if [they] have executed an advanced directive. If the resident has an advanced directive, a copy will become part of the resident's record.

The facility failed to ensure that R267 had Advanced Directives/Code Status noted on the physical chart or on the EMR, which could have resulted in a resident receiving CPR in the event of resident demise instead of the DNR as

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F 578	Continued From page 9 requested.	F 578		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or	F 622		

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discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including

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contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 58 residents, with 15 residents included in the sample and one resident reviewed for discharge. Based on interview and record review, the facility failed to document the required discharge information in Resident (R) 67's medical record.

Findings included:

- Review of Resident (R) 67's Electronic Health Record (EHR) revealed the following diagnoses: muscle weakness and difficulty in walking.

Review of the Admission "Minimum Data Set" (MDS) dated 06/15/21 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, which indicated intact cognition. R67 participated in the assessment. No active discharge planning occurred for the R67 to return to the community.

Review of the "Discharge MDS" dated 06/19/21 revealed the facility did not perform a BIMS. R67's memory was ok, and she independently made decisions regarding tasks of daily life. Active discharge planning occurred for R67 to return to the community with no referral needed.

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Review of the "Baseline Care Plan" revealed R67 was admitted to the facility for post-surgery skilled services due to a right hip fracture and wound healing.

Review of the "Nursing Order" entry dated 06/18/21 by Licensed Nurse (LN) R revealed: "Resident will discharging from Lakepoint of Wichita going home on 06/19/2021."

Review of R67's medical records lacked documentation of a discharge summary, recapitulation of the resident's stay, and post-discharge plan of care.

During an interview on 07/22/21 at 11:57 AM, Certified Nurse Aide (CNA) D stated R67 had discharged to Assisted Living.

During an interview on 07/22/21 at 08:26 AM, Licensed Nurse (LN) K stated that the nurse would get a packet from the social worker and orders from the doctor when a resident discharged. Additionally, LN K stated the resident and family representative should be educated about discharge information.

During an interview on 07/22/21 at 12:53 PM, Administrative Nurse B stated she expected a discharge summary, recapitulation, and facility staff should educate the resident or their representative regarding discharge. In addition, she would expect the nursing staff to document the education in the EMR.

Review of the "Admission, Transfer and Discharge Policy" revised 10/01/20 revealed, "Facility staff will document in the clinical record discharge information provided to the resident

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F 622	Continued From page 13 and the receiving organization..." The facility failed to document required discharge information in the medical records for R67.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		

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	175466	A. BUILDING _____ B. WING _____	07/22/2021

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F 623	Continued From page 14 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 623		

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agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
The facility census totaled 58 residents, with 15 residents included in the sample and one resident looked at for hospitalizations. Based on interview and record review, the facility failed to provide Resident (R) 6 or their representative a written notice for hospitalization.

Findings included:

- Review of R6's "Electronic Health Records" (EHR) revealed the following diagnosis: atrial fibrillation (rapid, irregular heartbeat) and benign prostatic hyperplasia/hypertrophy (non-cancerous enlargement of the prostate, which can lead to

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interference with urine flow, urinary frequency and urinary tract infections).

Review of the Admission "Minimum Data Set" (MDS) dated 02/19/21 revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition.

Review of an undated "Care Plan" revealed: R6 exhibited an altered level of consciousness (mental function fluctuation). Interventions included for staff to assess R6 for potential cause(s) for deterioration (lack of sleep, medication change, illness, change in routine/activities). R6 was also at risk for bleeding.

Review of a "Nursing Clinical Note" dated 03/01/21 by Licensed Nurse (LN) L revealed R6 had bright red blood from the rectum and having difficulty breathing. The physician ordered to send R6 to the hospital due to ongoing hematuria (blood in the urine) and bright red bleed from the rectum.

During an interview on 07/22/21 at 3:03 PM, Licensed Nurse (LN) K stated she did not remember R6. LN K stated nursing staff notified the family/DPOA of a resident needing to transfer to the hospital and why. LN K stated she would write a "Clinical Note" to document notifications, but she did not send anything in writing to the family or anyone else.

During an interview on 07/22/21 at 12:37 PM, Social Worker (SW) M stated she thought the nursing staff was supposed to notify the family when a resident went to the hospital. SW M stated she did not realize it was her responsibility

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F 623	Continued From page 17 to notify the ombudsman or family of R6's hospitalization. During an interview on 07/22/21 at 03:09 PM, Administrative Staff N stated that Social Services were responsible for notifying the family and the ombudsman in writing about resident transfers to the hospital. During an interview on 07/22/21 at 01:01 PM, Administrative Staff A stated she only realized a few months ago that the ombudsman had not been notified of resident hospitalizations. Administrative Staff A stated it was the facility practice to notify the resident's Durable Power of Attorney (DPOA) of hospitalizations. A policy was requested on 07/21/21concerning transfers/discharges, but no policy was provided which addressed resident, resident representative, and ombudsman notification of hospitalizations. The facility failed to notify the resident, resident representative in writing and failed to notify the ombudsman when R6 was hospitalized on 03/01/21.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625		

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F 625	Continued From page 18 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: The facility census totaled 58 residents, with 15 residents included in the sample and one resident looked at for hospitalizations. Based on interview and record review, the facility failed to provide Resident (R) 6 or their representative with a bed-hold policy upon transfer to a hospital. Findings included: - Review of R6's "Electronic Health Records" (EHR) revealed the following diagnosis: atrial fibrillation (rapid, irregular heartbeat) and benign prostatic hyperplasia/hypertrophy (non-cancerous enlargement of the prostate, which can lead to interference with urine flow, urinary frequency and urinary tract infections).	F 625		

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F 625	Continued From page 19 Review of the Admission "Minimum Data Set" (MDS) dated 02/19/21 revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. Review of an undated "Care Plan" revealed: R6 exhibited an altered level of consciousness (mental function fluctuation). Interventions included for staff to assess R6 for potential cause(s) for deterioration (lack of sleep, medication change, illness, change in routine/activities). R6 was also at risk for bleeding. Review of a "Nursing Clinical Note" dated 03/01/21 by Licensed Nurse (LN) L revealed R6 had bright red blood from the rectum and having difficulty breathing. The physician ordered to send R6 to the hospital due to ongoing hematuria (blood in the urine) and bright red bleed from the rectum. During an interview on 07/22/21 at 01:01 PM, Administrative Staff A stated social services, or the business office should provide information concerning bed holds. Review of the "Admission, Transfer and Discharge Policy" revised 10/01/20 revealed, "At the time of move in, transfer to another health care facility or overnight visits outside the facility, the resident and/or representative will be provided with information on how to hold the resident's current bedroom during their absence." The facility failed to provide R6 or his resident representative a written notice concerning the facility bed hold policy when R6 was discharged to the hospital.	F 625		

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F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer,	F 640		

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reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 58 residents with 15 residents in the sample; all were reviewed for Minimum Data Set (MDS) completion. Based on record review and interview, the facility failed to complete the required Discharge or Death MDSs in a timely manner for the discharges of resident (R)7, R1, R6, and R2, and the deaths of R4 and R3.

Findings included:

- Review of MDSs on 07/20/21 at 04:36 PM for the following residents revealed:
R3 was deceased on 01/30/21 with no "Death in Facility MDS" completed.
R2 was discharged to rehab on 02/04/21 with no "Discharge MDS" completed.
R4 deceased on 02/14/21 with no " Death in Facility MDS " completed.
R1 was discharged home on 03/01/21 with no "Discharge MDS" completed.
R6 was hospitalized on 03/01/21 and did not return to the facility; no "Discharge MDS" completed.
R7 was discharged home on 03/05/21 with no "Discharge MDS" completed.

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F 640	Continued From page 22 Interview with Administrative Nurse F on 07/21/21 at 11:00 AM revealed, "Those MDS should have been completed by the prior MDS Coordinator within 72 hours of discharge from the facility or death." She runs a "missing assessment report" twice a week and is working on completing all of the missing assessments since this issue was already identified by the facility. Interview with Administrative Nurse B on 07/21/21 at 02:16 PM revealed the MDSs should be completed and submitted timely within/following the Centers for Medicare/Medicaid Services and Resident Assessment Instrument (RAI) guidelines. She stated, "the facility audited all MDSs back in early May 2021 and had found a few missed MDSs not completed since the last MDS Coordinator quit". Review of the undated "Comprehensive Assessment Policy Including the MDS and CAAs" revealed the RAI process would be conducted and completed according to the regulatory requirements set by federal and state regulations. The facility failed to complete the required Discharge or Death MDSs in a timely manner for the discharges of R7, R1, R6, and R2, and the deaths of R4 and R3.	F 640		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course	F 661		

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F 661	Continued From page 23 of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: The facility census totaled 58 residents, with 15 residents included in the sample and one resident reviewed for discharge. Based on interview and record review, the facility failed to develop a discharge summary which included a recapitulation of the resident's stay, a final summary of the resident's status, reconciliation of all pre-and post-discharge medications, and develop a post-discharge plan of care, including discharge instructions for Resident (R) 67. Findings included: - Review of Resident (R) 67's Electronic Health Record (EHR) revealed the following diagnoses:	F 661		

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F 661	Continued From page 24 muscle weakness and difficulty in walking. Review of the Admission "Minimum Data Set" (MDS) dated 06/15/21 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, which indicated intact cognition. R67 participated in the assessment. No active discharge planning occurred for the R67 to return to the community. Review of the "Discharge MDS" dated 06/19/21 revealed the facility did not perform a BIMS. R67's memory was ok, and she independently made decisions regarding tasks of daily life. Active discharge planning occurred for R67 to return to the community with no referral needed. Review of the "Baseline Care Plan" revealed R67 was admitted to the facility for post-surgery skilled services due to a right hip fracture and wound healing. Review of the "Nursing Order" entry dated 06/18/21 by Licensed Nurse (LN) R revealed: "Resident will discharging from Lakepoint of Wichita going home on 06/19/2021." Review of R67's medical records lacked documentation of a discharge summary, recapitulation of the resident's stay, and post-discharge plan of care. During an interview on 07/22/21 at 11:57 AM, Certified Nurse Aide (CNA) D stated R67 had discharged to Assisted Living. During an interview on 07/22/21 at 08:26 AM, Licensed Nurse (LN) K stated that the nurse would get a packet from the social worker and orders from the doctor when a resident	F 661		

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F 661	Continued From page 25 discharged. Additionally, LN K stated the resident and family representative should be educated about discharge information. During an interview on 07/22/21 at 12:53 PM, Administrative Nurse B stated she expected a discharge summary, recapitulation, and facility staff should educate the resident or their representative regarding discharge. In addition, she would expect the nursing staff to document the education in the EMR. Review of the "Admission, Transfer and Discharge Policy" revised 10/01/20 revealed, "Facility staff will document in the clinical record discharge information provided to the resident and the receiving organization..." The facility failed to develop a discharge summary, recapitulation, and discharge instructions for R67.	F 661		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility census totaled 58 residents, with 15 included in the sample. One resident was reviewed for dialysis (the clinical purification of blood, as a substitute for the normal function of the kidney). Based on interview, observation, and record review, the facility failed to provide the	F 698		

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necessary care and service to attain or maintain a resident's highest practicable physical well-being related to dialysis by not documenting assessments of Resident (R) 46's dialysis fistula (connection made by a vascular surgeon, of an artery to a vein) site.

Findings included:

- Review of R46's "Electronic Health Record" (EHR) revealed the following diagnoses: dependence on renal dialysis and end-stage renal disease.

Review of the Admission "Minimum Data Set" (MDS) dated 05/31/21 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R46 received dialysis treatments.

A review of the undated "Care Plan" revealed: R46 had end-stage renal disease and required hemodialysis, which the facility performed.

Review of the physician orders revealed no order on file for R46 to received dialysis.

Review of the "Dialysis Transition of Care Form" revealed R46 received dialysis as scheduled from 05/19/21 through 07/21/21.

Review of the "Amended and Restated Long Term Care Facility Coordination Agreement For Certain Home Dialysis Related Services" signed 12/11/20 revealed, "Observe patients pre- and post-dialysis to ensure continuity of care, including the following activities:...monitoring access site for patency and infection; and identifying signs of bleeding..."

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An observation on 07/22/21 at 03:47 PM revealed R46 sat on the side of her bed in her room. R46 did not show any evidence of bleeding or other complications to her fistula.

During an interview on 07/22/21 at 03:47 PM, R46 stated the charge nurse didn't assess her fistula for bruit or thrill but that the dialysis nurse did this during her dialysis treatment.

During an interview on 07/21/21 at 01:21 PM, Certified Nurse Aide (CNA) J stated R46 received dialysis every day.

During an interview on 07/22/21 at 08:06 AM, Licensed Nurse (LN) K stated R46 went to dialysis every Monday-Friday. LN K stated she checked for bleeding, signs of infection, and bruit and thrill. LN K stated there was no order to do this, but she did it anyway but did not document this anywhere.

During an interview on 07/22/21 at 12:48 PM, Administrative Nurse B stated that nursing staff should assess the fistula site on dialysis residents for bleeding, check for thrill and bruit, and document this each time R46 came back from dialysis.

Review of the undated "Hemo-Dialysis Policy" revealed, "The following information will be documented in the elder's clinical record: vital signs, daily weight, date and time fistula assessed, presence or absence of bruit or thrill, condition of puncture site, presence of bleeding and any other abnormalities...signature and title of person assessing and recording data."

The facility failed to ensure nursing staff

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F 698	Continued From page 28 performed and documented post-dialysis assessments of R46's fistula site.	F 698		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility reported a census of 58 residents, with 15 sampled and five reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to follow the physician orders for hypertensive medications for Resident (R)49 and R11 and the facility failed to provide parameters for blood glucose (BG; blood sugar) for R49.	F 757		

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F 757	Continued From page 29 Findings included: - Review of R49's "Physician's Orders Electronic Medical Record" dated 06/30/21 included a diagnosis of Diabetes Mellitus (DM; when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and hypertension (HTN; high blood pressure). A review of the "Admission Change Minimum Data Set" (MDS) dated 03/18/21 documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. R49 received insulin (mediation that regulates the amount of glucose in the blood) seven out of a seven-day observation period. Review of the "Care Area Assessment" (CAA) dated 03/18/21 documented no applicable CAAs triggered. A review of the "Quarterly MDS" dated 05/17/21 documented a BIMS score of 11, indicating moderately impaired cognition. R49 received insulin seven out of a seven-day observation period. Review of the 02/25/21 "Care Plan" documented staff was to administer medications as ordered, monitor R49 for signs and symptoms of hyperglycemia (high blood sugar levels), complete blood glucose (BG; blood sugar), and notify the provider if the BG was above or below prescribed parameters. Review of the "Electronic Health Records" (EHR) "Physician Orders" documented the following: 03/12/21: Lisinopril (medication to reduce blood pressure) 10 milligrams (mg) tablet by mouth	F 757		

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F 757	Continued From page 30 (PO) every day for HTN 03/12/21: Metoprolol Tartrate (medication to reduce blood pressure) 25mg tablet PO twice a day for HTN 06/02/21: Metformin (medical to reduce blood sugar) 1,000mg tablet PO twice a day for DM 06/09/21: Accucheck (BG check) four times a day for DM 06/16/21: NovoLOG Flexpen (fast-acting insulin to reduce BG levels) 8 units subcutaneous (SQ; into the belly) once a day at 05:00 PM 06/28/21: NovoLOG Flexpen 13 units SQ once a day at 08:00 AM 06/28/21: NovoLOG Flexpen 11 units SQ once a day at 12:00 PM 06/26/21: Lantus Solostar (long-acting insulin to reduce BG levels) 19 units at bedtime Review of the "Physician's Standing Orders" dated 03/04/21 documented the following: 1. Check blood pressure weekly for hypertensive medications; notify the physician if the blood pressure is greater than 150 systolic (the pressure of the blood in the arteries when the heart pumps; the top number of a blood pressure reading) and greater than 90 diastolic (minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) for three days or less than 90 systolic and less than 40 diastolic for three days if asymptomatic (without symptoms). 2. Check pulse before administering a beta-blocker (metoprolol); hold the medication (do not give) if the pulse is less than 50. Notify physician if two consecutive doses are held Review of the 04/2021 through 07/2021 "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR)	F 757		

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F 757	Continued From page 31 documented a BG of 350 mg/dl or more [per Physician C's interview below] on the following days: 04/01: 414 04/03: 367 twice in one day 04/08: 354 04/12: 432 04/13: 381 04/16: 355 04/20: 354 04/22: 496 04/23: 379 05/01: 382 and 374 05/04: 353 05/14: 405 05/15: 357 05/18: 390 05/19: 372 05/28: 356 Review of the 04/2021 through 07/2021 "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR) documented a BG of 60 mg/dl or less [per Licensed Nurse K's interview below], with insulin given on the following days: 04/10: 60 06/14: 58 06/18: 57 06/25: 59 07/11: 56 07/20: 51 Review of the 04/2021 through 07/2021 "Vital Signs" documented blood pressure and pulse were obtained weekly for May, then only on 06/11/21, 06/12/21, 06/13/21, and 06/14/21. The medical record lacked documentation of vital signs after 06/14/21.	F 757		

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An interview with Certified Medication Aide (CMA) G on 07/22/21 at 08:56 AM revealed R49's vital signs were checked once a week by the Licensed Nurse (LN) on duty. CMA G stated that R49 did not have specific parameters associated with his HTN medication and that R49 would therefore be given the medication at each scheduled time unless he had a pulse of less than 60. CMA G stated she obtained BG throughout her shift and would notify the LN of any value greater than 250mg/dl or less than 90mg/dl.
An interview with LN K on 07/21/21 at 11:37 AM revealed R49's BG was checked four times a day and had no parameters to notify the provider or hold the medication associated with the BG. LN K stated that if R49's BG was less than 70mg/dl, she would provide a protein snack [to increase the BG] and recheck the BG 30 minutes later for effectiveness. LN K stated that if R49's BG was greater than 300mg/dl, she would assume that staff would call the provider for orders. LN K stated that staff did not check vital signs for R49's metoprolol or lisinopril and that the CMA was responsible for giving this medication to R49.

An interview with Administrator A and Administrative Nurse B on 07/22/21 at 09:21 AM revealed that they expected to have an order from the provider indicating how often R49's vital signs should have been checked in order to give the metoprolol and lisinopril. Because there was no specific order, [both parties] stated that R49's vital signs should have been checked at least monthly unless R49 was symptomatic. [Both parties] stated there was a standing order to hold beta-blockers for a pulse less than 50 and to notify the provider but were unaware of any other orders. [Both parties] expected staff to follow the

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standing orders provided by the physician unless otherwise indicated. Administrative Nurse B stated that she was unsure of a standing order for BG, but that she expected there to be an order for all residents with BG checks.

An interview with Physician C on 07/22/21 at 02:07 PM revealed that the best practice would be for both lisinopril and metoprolol to have parameters attached to the order. Physician C stated facility staff should follow the standing orders unless the physician canceled the order. Physician C stated that vital signs should have been taken monthly to ensure the medication was working for the resident. Still, because the standing order was in place, he expected staff to obtain vital signs weekly. Physician C was unsure why R49 did not have parameters associated with his BG checks and stated that R49 needed parameters. Physician C stated he wanted to know about all BG values greater than 350 or low [no value indicated by a physician]. Physician C stated that it was important for him to know the BG value outside of the range [stated] to ensure R49 was getting the appropriate amount of insulin to treat R49's DM.

Review of the undated "Administering Medications" policy documented each elder's drug regimen would be free from unnecessary drugs, meaning all medications would be given with adequate and recommended monitoring from the physician. Staff was to check a pulse before administering any cardiac rhythm medications [metoprolol] and document and follow holding/notification parameters ordered by the physician. Staff was to obtain weekly blood pressures for all HTN medications unless otherwise indicated by the physician.

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F 757	Continued From page 34 The facility failed to adequately follow the physicians' standing order to obtain vital signs weekly and failed to obtain parameters for BG checks for R49. - Review of Resident (R)11's signed "Physician Orders" dated 6/23/21 revealed the following diagnoses: hypertension (HTN-elevated blood pressure). Review of the "Admission Minimal Data Set (MDS)" dated 01/21/21 revealed a brief interview for mental status (BIMS) score of 06, indicating severe cognitive impairment. The resident received an antidepressant seven days of the seven-day observation period. Review of the quarterly "Minimum Data Set" dated 04/23/21 revealed no significant changes since the MDS dated 01/21/21. Review of the "Care Plan" dated 01/22/21 lacked medication information. Review of the "Physician Signed Orders" dated 07/01/21 included Amlodipine (high blood pressure medication) 5 milligrams (mg) 1 by mouth (PO) daily starting on 06/22/21. The staff was instructed to hold the medication if R11's blood pressure was below 120 millimeters of mercury (mm/hg) systolic (the top number on the blood pressure reading) due to the risk of falling. Review of the "Medication Administration Record" (MAR) for July 2021 revealed R11's blood pressure was below 120 mm/hg systolic on 07/09/21, 07/12/21, and 07/17/21, with the medication documented as administered.	F 757		

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F 757	Continued From page 35 Observation on 07/21/21 at 10:00 AM revealed Certified Nursing Assistant (CNA) E wheeled the resident to his room and placed a gait belt on the resident. CNA E assisted the resident to stand and hang onto grab bars. The resident was unsteady on his feet during the transfer. 07/22/21 at 9:15 AM interview with Certified Medication Aide (CMA) G reported she did not think the resident had his blood pressure taken with his medications. She was unaware of any parameters. During an interview on 07/22/21 at 9:30 AM, Licensed Nurse (LN) I reported he was unaware of any parameters written by the physician. He reported the CMA giving the medication should get the vital signs, and if out of the set parameters, they are to report to the nurse, and the medication is to be held. No CMA has made him aware of the need to hold any medication. During an interview with Administrative Nurse B and Administrative Staff A on 07/22/21 at 10:00 AM reported they expected the staff to follow physician parameters and hold medication as indicated. Review of the undated facility policy named "Medication Administration Policy" revealed all medications would be administered to every elder as ordered by a physician in a safe and sanitary manner. Each elder's drug regimen will be free from unnecessary drugs, defined as: Without adequate, recommended monitoring. The facility failed to ensure R11's medication regimen was free of unnecessary medications by	F 757		

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F 757	Continued From page 36 the failure to follow parameters set by the physician before giving the medication.	F 757		