STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087162	A. BUILDING: _____ B. WING _____	11/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJORIE'S HOME LLC	14601 TIMBER LAKE ROAD WICHITA, KS 67230

(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 for the above named facility conducted on 11/17/2020, 11/18/2020 and 11/19/2020.	S 000		
S5205 SS=F	26-42-104 (a) Disaster and Emergency Preparedness a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (a) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review, observation, and interview the operator failed to ensure the provision of a sufficient number of staff members to take resident #232 to a secure location in the event of an emergency or disaster. Resident #232 required the assistance of 2 persons with a mechanical lift to transfer from the bed to a wheelchair. This deficient practice had the potential to affect all residents if only 1 staff member was on duty and tied up with a resident needing a 2-person transfer. Findings included: - Record review for resident #232 revealed an admission date of 08/06/2020 with diagnoses of Epilepsy, hypertension, chronic pain, and anxiety. The admission functional capacity screening	S5205		

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

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S5205	Continued From page 1 (FCS) dated 08/06/2020 identified the resident with intact cognition, he required physical assistance with bathing, dressing, toileting, transferring and marked as unable to perform walking/mobility. He used assistive devices of a wheelchair and a mechanical lift. Compared to the significant change FCS dated 09/14/2020 the resident had a decline in his decision-making ability and now at risk for a fall. The admission negotiated service agreement (NSA) dated 08/06/2020 included the following services provided by the facility: physical assistance (NSA lacked number of staff required for assistance) with toileting, bathing, and dressing. The resident could communicate his needs, was alert, and orientated to person, place and time. He used a wheelchair and a mechanical total body lift with assistance from 2 staff for transfers. The resident's care plan dated 08/06/2020 directed staff to transfer the resident using a mechanical lift and 2 persons to operate the lift. Review of the monthly care plan sheets for September, October and November 2020 included the same directions. Observation on 11/17/2020 between 3:25 PM to 3:33 PM revealed certified medication aide (CMA) A and certified nurse aide (CNA) B assisted the resident from his bed to a wheelchair with a mechanical total body lift. The total time required to get the resident from the bed to the wheelchair equaled 8 minutes. Interview on 11/17/2020 at 3:25 PM with CMA A revealed staff were instructed to lower the resident to the floor with a sheet and drag him to a safe area.	S5205		

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S5205	Continued From page 2 During an interview on 11/17/2020 at 1:10 PM with Licensed nurse C, she stated a slide board was purchased and delivered on 11/16/2020, she did not indicate why the slide board was not purchased in September 2020 when staffing was reduced to 1 person on the night shift. She stated, the facility staff were waiting for training on how to properly use the slide board to transfer the resident. Licensed nurse C did not indicate who would provide training for the slide board. Interview on 11/17/2020 with Operator D confirmed she planned one staff member for the overnight shift since approximately 09/19/2020. Operator D reported the reduction of staff is related the census of 5 residents. Operator D did not give a reason for not purchasing a slide board in September 2020 when the staffing was reduced. Operator D stated the staff were verbally instructed to lower resident #232 to the floor with a sheet/blanket and drag to a safe area. She provided no evidence of training staff in this maneuver. On 11/17/2020 at 4:20 PM Operator D received notification from the surveyor of the concern for safety of resident #232 needing a 2-person transfer and the potential safety of all residents for assistance to evacuate in an emergency. She began making arrangements for a second staff member for the overnight shift. On 11/18/2020 at 10:00 AM after being told of the concern for safety of the residents in an emergency, operator D provided the following: signed instructions from physical therapist E dated 11/17/2020. A statement which indicated the therapist trained licensed nurse C and CMA A on the use of the slide board, and the resident could be safe with one-person emergency sliding	S5205		

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S5205	Continued From page 3	S5205		

board transfer from bed to wheelchair. Operator D confirmed not all staff were trained yet to safely transfer resident #232 with the slide board.

- On 11/17/2020 certified medication aide (CMA) A provided the resident roster. The roster identified all 5 residents were cognitively impaired, resident (#232) required a 2 person assist for transfers, and the other 4 residents required staff assistance with activities of daily living and/or transfers. CMA A confirmed resident #232 required a 2 person assist with a total body mechanical lift for transfers between surfaces (bed/chair, to/from).

On 11/17/2020 at 1:10 PM licensed nurse C reported the facility staffing as 2 staff during the day, and 1 staff overnight. She stated night shift had only 1 staff since approximately 09/19/2020.

Review of the working staff schedules dated 09/2020, 10/2020, and 11/2020 revealed 2 staff names listed to work on the overnight shift. Licensed nurse C stated the working schedule had not been updated to reflect the planned 1 staff on the overnight. Licensed nurse C stated she left the second names on the night shift schedule as a reminder of "where she works ...for that purpose", for scheduling purposes when 2 staff are to be on the night shift.

Review of the facility's emergency drills revealed evacuation drills performed bi-monthly with last evacuation performed on 09/30/2020 at 8:20 PM to the front door of the facility. The drill included 5 residents in wheelchairs were evacuated to the front door. The report lacked the minutes it took to perform the evacuation and licensed nurse C could not recall the length of time. The report indicated 1 certified medication aide on duty

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S5205	Continued From page 4 performed the evacuation and licensed nurse C supervised the drill. The report did not indicate if residents were already in wheelchairs or if staff had to get them out of bed. Interview on 11/17/2020 at 4:00 PM with Operator D confirmed she planned only 1 staff on the overnight shift since approximately 09/19/2020 because of decreased census to 5 residents, and when census reached 6 residents, she would hire another staff for the night shift. For all of the above findings, the operator failed to ensure the provision of a sufficient number of staff members to take resident #232 to a secure location in the event of an emergency or disaster. Resident #232 required the assistance of 2 persons with a mechanical lift to transfer from the bed to a wheelchair. This deficient practice had the potential to affect all residents if only 1 staff member was on duty and tied up with a resident needing a 2-person transfer.	S5205		