STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087137	A. BUILDING: _____ B. WING _____	C 09/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS OF WICHITA LLC	6311 E MARJORIE ST WICHITA, KS 67208

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S 000	INITIAL COMMENTS The following citations represent the findings of the resurvey and complaint investigation #148933 conducted on 08/31/2020, 09/01/2020, 09/02/2020 and 09/03/2020.	S 000		
S5095 SS=D	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-42-201 (d) The facility reported a census of 7 residents. The sample included 3 residents and 1 focused closed record. Based on interview and record review the operator failed to ensure 1 of 3 sampled resident's (#623) functional capacity screen, at time of screening, accurately reflected the resident's functional capacity regarding wandering and socially inappropriate disruptive behavior. Findings included: - Record review revealed resident #623 re-admitted to the facility on 01/15/2020 with diagnoses of major depressive disorder, suicidal idealization, alcohol abuse, dementia, Alzheimer's, and anxiety. The significant change functional capacity screen	S5095		

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

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S5095	Continued From page 1 (FCS) dated 04/14/2020 identified the resident with cognitive impairment in all aspects. She lacked the ability to bath, dress or toilet and required physical assistance with transfers, walking/mobility and eating. She could not manage her own medications, had impaired communication; sometimes understood and sometimes understands others. In comparison to the readmission FCS dated 01/15/2020 the resident had the same cognition, needed physical assistance for all activities of daily living, same communication and she was marked for wandering behavior. This FCS did not indicate she had socially inappropriate behaviors. The negotiated service agreement (ALIS Resident Evaluation) dated 04/14/2020 included staff total performance for bathing, dressing and toileting with physical assistance for all other activities of daily living. The section for Safety had 5 components. Licensed nurse C marked the resident with a history of wandering and/or eloping, occasionally disoriented and/or usually agitated or combative and she took medication for verbal, emotional, or physical outburst. Licensed nurse C wrote in the notes portion for door alarms to stay in the on position and staff to check the resident hourly. Under the section for special considerations licensed nurse C marked the resident as able to make some needs known but had difficulty making all needs known and needed assistance to make choices. Licensed nurse C marked the resident had behaviors which require assistance or monitoring, and, in the notes, she wrote staff to monitor resident's behaviors and any unusual behavior will be noted. The NSA lacked what those behaviors included.	S5095		

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S5095	Continued From page 2 The individual service plan (ISP) dated 04/14/2020 directed staff to provide assistance with routine cares in the AM/PM, meals and toileting. Under emotional health-assistance - staff to monitor the resident's behavior, any unusual behavior will be noted and without any specific behaviors indicated. Staff to invite the resident to group activities which stimulate cognition, encourage the resident to engage in independent activities which stimulate cognition (reading, word games and puzzles etc.) However, the resident's cognition would not allow for her to do these independent cognition stimulating activities. Review of medical care provider's order report signed on 01/15/2020 revealed an order for Ziprasidone HCl (an antipsychotic) 20 milligrams (mg) by mouth (PO) twice daily for behaviors/aggression/agitation. Remeron 15 mg PO daily for appetite/depression/dementia and Citalopram Hydrobromide 20 mg PO daily for depression and Ativan (antianxiety) 0.5 mg 1 tablet PO every hour as needed (PRN) for anxiety. Review of the August 2020 medication administration record (MAR) revealed the resident received all of the above medications with PRN doses as follow: 08/01/2020 6:13 PM Ativan 0.5 mg for increased anxiety & agitation and Ziprasidone 20 mg for increased agitation 08/10/2020 at 2:44 PM Ziprasidone 20 mg for increased agitation 08/11/2020 at 2:41 AM Ativan 0.5 mg for anxiety 08/15/2020 at 5:18 PM Ziprasidone 20 mg for increased agitation 08/19/2020 at 1:15 PM Ativan 0.5 mg for increased anxiety and agitation	S5095		

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S5095	Continued From page 3 08/20/2020 at 12:30 PM for increased anxiety and agitation Review of the nursing notes between 06/04/2020 and 08/20/2020 revealed an entry on 06/05/2020 at 1:17 PM ... "small behavior mid-morning (did not say what kind of behavior), sat out on back porch and resident calmed". The notes lacked any information about the resident's behaviors or anxiety symptoms for the use of the PRN medications as listed above. Interview on 09/01/2020 at 4:00 PM with licensed nurse C revealed the resident still had occasional wandering behavior and other socially inappropriate disruptive behaviors including screaming, hollering, striking herself or banging her fist on the wall. She confirmed the FCS failed to identify the resident's wandering and inappropriate behaviors. The operator failed to ensure this resident's functional capacity screen accurately reflected the resident's functional capacity regarding wandering and socially inappropriate disruptive behaviors.	S5095		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus 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	S5105		

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S5105	Continued From page 4 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 26-42-202 (a)(1)(2)(3) The facility reported a census of 7 residents. The sample included 3 residents and 1 focused closed record. Based on interview and record review the operator failed to ensure the negotiated service agreement had an accurate description of service provided by an outside sources, identification of the provider of each services and the party responsible for payment if the outside resources provided a service for 3 of 3 sampled residents (#413, #620 and #729). Findings included: - Review of the record for resident #413 revealed an admission date of 08/27/2020 with diagnosis of Parkinson's, dementia, delusions, dysphagia level 3 and acute pain. The admission negotiated service agreement (ALIS Resident Evaluation) dated 08/27/2020 indicated the resident received outside provider services for home health of PT/OT/ST (physical, occupational and speech therapies). Licensed nurse C marked the resident was fully dependent on staff to communicate with physicians but did not list the medical provider for the resident who made visits to the facility.	S5105		

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S5105	Continued From page 5 Record review revealed no indicators the resident received the services from the named outside provider. Interview on 09/02/2020 at 10:30 AM with operator B confirmed the resident does not currently received any outside provider services. She confirmed the resident's medical care provider came to the facility to provide services and the negotiated service agreement failed to include this information. - Record review for resident #729 initially started on 09/01/2020 at 10:25 AM revealed an admission date of 06/12/2020 with diagnoses of cerebral infarct without residual, dementia without behaviors, hypertension, cognitive communication deficit and anemia. The admission functional capacity screen dated 06/12/2020 identified the resident with impaired cognition in all aspects and required physical assistance with bathing, dressing and toileting. She had a risk for falls or unsteadiness. The negotiated service agreement (ALIS Resident Evaluation) dated 06/12/2020 included outside providers for services from a home health for PT/OT/ST (physical, occupational and speech therapies). At the time of record review, the electronic record had a document dated 06/16/2020 for the start of service but no end date of service and signatures. Later on, 09/02/2020 licensed nurse C provided a paper document with the end date and signature of 08/14/2020. The negotiated service agreement (NSA) included provider for medical providers of Mobile Medical. The resident's demographic page	S5105		

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S5105	Continued From page 6	S5105		

listed a physician not associated with mobile medical as the medical provider. Nursing notes indicated the resident received outside services from a podiatrist, but the NSA lacked this outside provider, what services they provided and the party responsible for payment.

Review of the nursing notes (Observations) revealed an entry dated 06/24/2020 at 1:00 PM podiatrist F came to the facility for evaluation and treatment and planned to visit every 3 months.

Interview on 09/02/2020 at 10:35 AM operator B confirmed the electronic NSA lacked the podiatrist, correct physician or medical group and the end date of PT/OT/ST services.

- Record review revealed resident #623 re-admitted to the facility on 01/15/2020 with diagnoses of major depressive disorder, suicidal idealization, alcohol abuse, dementia, Alzheimer's, and anxiety.

The significant change functional capacity screen (FCS) dated 04/14/2020 identified the resident with cognitive impairment in all aspects. She lacked the ability to bath, dress or toilet and required physical assistance with transfers, walking/mobility and eating. She could not manage her own medications, had impaired communication; sometimes understood and sometimes understands others.

The negotiated service agreement (ALIS Resident Evaluation) dated 04/14/2020 included staff total performance for bathing, dressing and toileting with physical assistance for all other activities of daily living. Nursing notes indicated the resident received outside services from a

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S5105	Continued From page 7 podiatrist but the NSA lacked this outside provider, what servives they provided and the party responsible for payment. Review of the nursing notes between 06/04/2020 at 08/20/2020 revealed an entry dated 06/24/2020 at 1:00 PM podiatrist F came to the facility for evaluation and treatment with a return visit planned for 3 months. Interview on 09/02/2020 at 10:35 AM operator B confirmed the electronic NSA lacked the podiatrist. For all of the above findings, the operator failed to ensure the negotiated service agreemnt had an accurate description of services provided by an outside sources, identification of the provider of each service and the party responsible for payment if the outside resources provided a service for 3 of 3 sampled residents (#413, #620 and #729).	S5105		
S5155 SS=D	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced	S5155		

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S5155	Continued From page 8 by: KAR 26-42-204 (a) The facility reported a census of 7 residents. The sample included 3 residents and 1 focused closed record. Based on interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health caer services to mee the needs of each resident, in accordance with the functional capacity screening and the negotiated services agreement for 1 of 3 (#623) sampled residents regarding falls and behaviors. Finding included: - Record review revealed resident #623 re-admitted to the facility on 01/15/2020 with diagnoses of major depressive disorder, suicidal idealization, alcohol abuse, dementia, Alzheimer's, and anxiety. The significant change functional capacity screen (FCS) dated 04/14/2020 identified the resident with cognitive impairment in all aspects. She lacked the ability to bath, dress or toilet and required physical assistance with transfers, walking/mobility and eating. She could not manage her own medications, had impaired communication; sometimes understood and sometimes understands others. The resident had a history of falls and impaired vision. In comparison to the readmission FCS dated 01/15/2020 the resident had the same cognition, needed physical assistance for all activities of daily living, same communication and fall risk but she was marked for wandering behavior. This FCS did not indicate she had socially inappropriate behaviors.	S5155		

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S5155	Continued From page 9 The negotiated service agreement (ALIS Resident Evaluation) dated 04/14/2020 included staff total performance for bathing, dressing and toileting with physical assistance for all other activities of daily living. The section for Safety had 5 components. Licensed nurse C marked the fall risk assessment as resident disoriented and confused at times or always, sight impairment, needed an assistive device, inability to understand and follow directions, and took medications which increased her risk. Licensed nurse C marked the resident needed a fall management program. She also marked the resident with a history of wandering and/or eloping, occasionally disoriented and/or usually agitated or combative and she took medication for verbal, emotional, or physical outburst. Licensed nurse C wrote in the notes portion door alarms to stay in the on position at all times and staff to check the resident hourly. Under the section for special considerations licensed nurse C marked the resident as able to make some needs known but had difficulty making all needs known and needed assistance to make choices. Licensed nurse C marked the resident had behaviors which require assistance or monitoring, and, in the notes, she wrote staff to monitor resident's behaviors and any unusual behavior will be noted. The NSA lacked what those behaviors included. The individual service plan (ISP) dated 04/14/2020 directed staff to provide assistance with routine cares in the AM/PM, meals and toileting. Under emotional health-assistance - staff to monitor the resident's behavior and any unusual behavior will be noted without any specific behaviors indicated or any interventions to address behaviors. Staff to invite the resident	S5155		

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S5155	Continued From page 10	S5155		

to group activities which stimulate cognition, encourage the resident to engage in independent activities which stimulate cognition (reading, word games and puzzles etc.) However, the resident's cognition would not allow for her to do these independent cognition stimulating activities. The ISP included a fall management program with an update on 01/02/2020 which included the following: bed to be lowered to the floor at all times during resident resting periods and hour of sleep, fall mat to remain in place at all times while resident is in bed, staff to check on resident every 15 minutes while she is in her room or resting in her recliner. No other dated revisions were indicated on her ISP.

Review of facility's incident reports revealed: On 01/02/2020 resident not sleeping and yelling out, with hallucinatory behavior and slide to the floor from her bed. Action taken, frequent checks on the resident report any and all changes to the nurse. The ISP already included every 15-minute checks, the ISP lacked a new intervention to address the causal factors of the fall. No other actions to address hallucinations or restlessness were addressed. On 03/02/2020 the resident fell when she got up to go to the bathroom and fell against the wall when trying to walk through the door of the bathroom. Action taken by staff included frequent checks while in her room, every 2-hour check and change, fall mat in place/proper position. The ISP lacked a revision to ensure all staff knew of these changes as a result of the fall. 04/14/2020 The facility's incident report indicated staff found the resident on the floor in the middle of the hallway and she had been on her way to the bathroom. The written actions taken were the already planned intervention and nothing added to address the causal factor of this fall. On 05/13/2020 incident report revealed resident

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S5155	Continued From page 11	S5155		

missed the chair and fell straight down on her bottom. Action taken assessment for injuries. The ISP failed to identity this fall, causal factors and interventions staff should use to minimize the risk for future falls.

Review of medical care provider's order report signed on 01/15/2020 revealed an order for Ziprasidone HCl (an antipsychotic) 20 milligrams (mg) by mouth (PO) twice daily for behaviors/aggression/agitation. Remeron 15 mg PO daily for appetite/depression/dementia and Citalopram Hydrobromide 20 mg PO daily for depression and Ativan (antianxiety) 0.5 mg 1 tablet PO every hour as needed (PRN) for anxiety.

Review of the August 2020 medication administration record (MAR) revealed the resident received all of the above medications with PRN doses as follow:
08/01/2020 6:13 PM Ativan 0.5 mg for increased anxiety & agitation and Ziprasidone 20 mg for increased agitation
08/10/2020 at 2:44 PM Ziprasidone 20 mg for increased agitation
08/11/2020 at 2:41 AM Ativan 0.5 mg for anxiety
08/15/2020 at 5:18 PM Ziprasidone 20 mg for increased agitation
08/19/2020 at 1:15 PM Ativan 0.5 mg for increased anxiety and agitation
08/20/2020 at 12:30 PM for increased anxiety and agitation

Review of the nursing notes between 06/27/2020 and 08/20/2020 revealed an entry on 06/05/2020 at 1:17 PM ... "small behavior mid-morning (did not say what kind of behavior), sat out on back porch and resident calmed". The notes lacked any information about the resident's behaviors or

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S5155	Continued From page 12 anxiety symptoms for the use of the PRN medications as listed above. Interview on 09/01/2020 at 4:00 PM with licensed nurse C revealed the resident still had occasional wandering behavior and other socially inappropriate disruptive behaviors including screaming, hollering, striking herself or banging her fist on the wall. She confirmed failure to have interventions to manage behaviors and failure to revise the care plan with each fall. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health caer services to mee the needs of each resident, in accordance with the functional capacity screening and the negotiated services agreement for this residents regarding falls and behaviors.	S5155		
S5185 SS=E	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian.	S5185		

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S5185	Continued From page 13 This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (c) The facility reported a census of 7 residents. The sample included 3 residents and 1 focused closed record review. Based on observation, interview and record review the operator failed to ensure 2 of 3 sampled residents (#413 and #729) received mechanically altered diets or thickened liquids in accordance with instruction from a medical care provider or licensed dietitian. Findings included: - Record review for resident #413 revealed an admission date of 08/27/2020 with diagnoses of Parkinson's, dysphagia level 3, and dementia. The admission functional capacity screen dated 08/27/2020 identified the resident with short-term memory deficit and impaired decision making. He needed physical assistance for bathing, dressing, toileting and eating. The admission negotiated service agreement (ALIS Resident Evaluation) dated 08/27/2020 included services of a soft mechanical diet and nectar thickened fluids. He required staff assistance (including with adaptive equipment) to feed himself. The individual service plan dated 08/27/2020 directed staff the resident should have a soft mechanical diet and nectar thickened fluids, report to the nurse with any concerns with eating and swallowing issues. The service plan lacked any directions for how to prepare the foods or beverages.	S5185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087137	A. BUILDING: _____ B. WING _____	C 09/03/2020

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S5185	Continued From page 14 Verbal medical care provider's orders obtained by licensed nurse C on 08/27/2020 included to provide a soft mechanical diet with nectar thickened fluids. These orders failed to include written instructions on specifics of the diet or how to prepare the diet. Observation on 09/01/2020 at 12:15 PM revealed direct care staff A prepared the mechanically altered meal for the resident. She reported cutting up 1 cooked pork cutlet into small pieces, adding an unmeasured amount of gravy and water to the food blender and processing for a minute or so. She reported she checked the consistency to ensure there were no chunks of meats and the consistency of the meat was as a thin almost liquid. She then prepared cooked/canned green beans. She placed 2 tablespoons (approximately 2-3 ounces and not the 1 cup standard serving size) to this she added an unmeasured amount of liquid from the green beans and processed until it was liquid which ran over the plate when placed on the plate. Direct care staff did not refer to any instructions or recipes. She attempted to drain some of the green bean juice before serving the plate to the resident. Observation on 09/01/2020 at 12:28 PM revealed direct care staff A poured an unmeasured amount of cranberry juice into a glass, looked at the directions on the label for "Thick-it" (a brand of powder thickening agent) and placed 3 tablespoons into the juice stirring with a fork. When asked how much liquid was in the cup, she said about 6 ounces. She then poured into a measuring cup and it was more than 8 ounces at approximately 10 ounces. She served it to the resident and when asked what consistency she made she said honey thick and then said nectar	S5185		

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	B087137	A. BUILDING: _____ B. WING _____	C 09/03/2020

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S5185	Continued From page 15	S5185		

thick, but it thickens up more as it sits.

On 09/01/2020 at 12:48 PM operator B reported the instructions for mechanically altered diets were posted on a clipboard in the kitchen. Review of the documents posted revealed only directions for a "Pureed diet". Operator B confirmed the resident's record failed to include written instructions signed by a medical care provider or licensed dietitian regarding a mechanical soft diet and nectar thickened liquids for this resident.

The operator failed to ensure resident #413 received mechanically altered diet and thickened liquids in accordance with instruction from a medical care provider or licensed dietitian.

- Record review for resident #729 revealed an admission date of 06/12/2020 with diagnoses of cerebral infarct without residual, dementia without behaviors, hypertension, cognitive communication deficit and anemia.

The admission functional capacity screen dated 06/12/2020 identified the resident with impaired cognition in all aspects and required supervision with eating.

The negotiated service agreement (ALIS Resident Evaluation) dated 06/12/2020 on the first page her diet listed regular. Under the dietary section licensed nurse C marked the resident is on a physician ordered special diet and, in the notes, she wrote regular soft diet.

The individual service plan dated 06/12/2020 on the first page listed a regular diet. Under meal tracking licensed nurse C wrote soft regular diet.

The verbal order from medical care provider D

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	B087137	A. BUILDING: _____ B. WING _____	C 09/03/2020

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S5185	Continued From page 16 (not signed) dated 06/12/2020 included a regular soft diet. A recap of orders signed by medical care provider without a date by the signature but at the bottom of the last page included an electronic signature on 09/01/2020 which included a soft regular diet. The record lacked orders changing the diet to a regular diet. The medication administration record August 2020 listed the resident's diet as regular. Observation on 09/01/2020 at the noon meal revealed the resident received a regular diet. On 09/02/2020 at 11:30 AM licensed nurse C said, her expectation of a regular soft diet meant mechanical soft. She confirmed the record lacked instructions for the resident from a medical care provider or licensed dietician for the ordered regular soft diet. She said the resident's diet was changed to a regular diet and confirmed the resident received a regular diet. On 09/02/2020 at 11:30 AM operator B confirmed the diet ordered needed to be clarified and if the resident needed a mechanically altered diet, they would obtain written instructions from the medical care provider. The operator failed to ensure the resident received the mechanically altered soft diet as ordered by a medical care provider and failed to have written instructions on how to prepare the items from a medical care provider or dietician.	S5185		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure	S5215		

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S5215	Continued From page 17 disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' 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 26-42-104 (d) (3) The facility reported a census of 7 residents. Based on record review and interview, operator B failed to ensure disaster and emergency preparedness for employees and residents every quarter as evidence by the documentation provided which failed to include all elements of the emergency plan. Findings included: - Review of emergency management training records on 08/31/2020 provided by Operator B, revealed signature pages for residents on the following dates: 01/20/2020 for fire drill and evacuation participation, 03/23/2020 illegible hand written title, 04/04/2020 fire drill, COVID 19 social distancing, and 06/11/2020 fire drill evacuation and weather safety, COVID 19 education and update.	S5215		

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S5215	Continued From page 18 Review of staff sign in sheets for the following dates revealed 2 pages for 03/20/2020, 1 titled fire and safety quarterly, 1 document titled COVID 19 with the rest illegible, 06/17/2020 titled fire and safety with the rest of title illegible. The signatures of staff on both documents were in the same handwriting for all signatures. Interview on 08/31/2020 at 3:15 PM with Operator B confirmed the signatures of staff participating were all done in her hand writing, and operator B provided a written statement confirming she wrote down the list of names of participants in the quarterly fire and disaster plan as she only had one signature page for the 2 activities. Operator B confirmed the documents provided failed to indicate all elements of the emergency plan were reviewed at least quarterly. Operator B failed to ensure disaster and emergency preparedness for employees and residents every quarter as evidence by the documentation provided which failed to include all elements of the emergency plan.	S5215		
S5258 SS=E	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (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	S5258		

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S5258	Continued From page 19 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 carehome; 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 work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102 (d)(1) The facility reported a census of 7 residents. Based on record review and interview the operator failed to have evidence of licensing verification for licensed nurse C prior to the start of employment. The operator further failed to have date stamped evidence of verification prior to providing care from the Kansas nurse aide registry for 2 of 4 newly hired direct care staff employees (certified medication aide {CMA} G and certified nurse aide {CAN} H) with the potential to care for all residents. Findings included: - On 09/01/2020 at 3:45 PM operator B provided a list of employees hired since the last resurvey with 5 employee files reviewed. Record review revealed 2 of 5 newly hired direct care staff (CNA H, CMA G) had a single page document to indicate the operator checked with	S5258		

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S5258	Continued From page 20	S5258		

the nurse aid registry. Neither CMA G nor CNA H had a date on the page of when the verification occurred to ensure the verification was prior to providing care.

Record review for licensed nurse C revealed a start date of 04/20/2018 and her record lacked any evidence of the license verification from the Kansas state board of nursing prior to providing care.

Interview with operator B confirmed the documents from the Kansas nurse aid registry lacked a date stamp of when the verification was made, and licensed nurse C's file lacked evidence of the verification from the Kansas state board of nursing.

The facility's undated policy titled, selection of personnel included "verify licensure of all professionals for whom licensure or certification is required". The undated facility policy on Abuse, Neglect or Exploitation directed the home will not employ any individual who has been identified on a state nurse aide registry as having abused, neglected or exploited any resident in an adult care home.

The operator failed to have evidence of licensing verification for licensed nurse C prior to the start of employment. The operator further failed to have date stamped evidence of verification prior to providing care from the Kansas nurse aide registry for 2 of 4 newly hired direct care staff employees (certified medication aide {CMA} G and certified nurse aide {CAN} H) with the potential to care for all residents.

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S5300	Continued From page 21	S5300		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d) The facility reported a census of 7 residents. The sample included 3 residents and 1 focused review. Based on record review and interview the operator failed to ensure staff administered 1 of 3 sampled resident's (#413) medications in accordance with a medical care provider's written order and professional standards of practice. Findings included: - Record review for resident #413 revealed an admission date of 08/27/2020 with diagnoses of Parkinson's, dysphagia level 3, and dementia.	S5300		

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S5300	Continued From page 22 The admission functional capacity screen dated 08/27/2020 identified the resident with short-term memory deficit and impaired decision making. He could not manage his own medications and treatments. The admission negotiated service agreement (ALIS Resident Evaluation) dated 08/27/2020 indicated the resident was completely dependent on staff for assistance with all medication administration. The individual service plan dated 08/27/2020 directed staff to administer the resident's medications. Review of the August 2020 medication administration record (MAR) revealed the resident received the following medications beginning on 08/28/2020: Carbidopa-Levodopa 25-100 milligrams (mg), 1.5 tablets by mouth (PO) every morning Carbidopa-Levodopa 25-250 mg 1 tablet PO twice a day (BID) Docusate sodium 10mg/milliliter (ml), give 10 ml PO BID Quetiapine Fumarate 50 mg PO daily Selegiline hydrochloride 5 mg PO BID Tamsulosin hydrochloride 0.4 mg 2 capsules daily The MAR also listed the following PRN (as needed) medications: Acetaminophen 325 mg give 2 tablets every 4 hours PRN pain Ativan 0.5 mg 1 every 4 hours PRN increased anxiety Haldol 0.5 mg give 1 tablet PO every 4 hours PRN Milk of Magnesia give 30 ml PO PRN for GI upset Zofran 4 mg give 1 tablet every 6 hours PRN	S5300		

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S5300	Continued From page 23 Record review comparing the electronic and paper records provided revealed no signed orders by a medical care provider to administer the above medications. The record had a discharge list of medications from the hospital prior to his admission and no medical care provider's orders to follow those medications. On 09/01/2020 medical care provider E came to the facility and signed medications orders as well a changing some. Interview on 08/31/2020 at 3:30 PM with licensed nurse C and operator B confirmed the electronic and paper record lacked signed medical care provider's orders for the medications above at the time of admission. The operator failed to ensure staff administered resident #413 medications in accordance with a medical care provider's written order and professional standards of practice.	S5300		
S5310 SS=D	26-42-205 (e) (f) (g 1 - 3) Medication Orders, Ordering, Labeling (e) Medication orders. Only a licensed nurse or a licensed pharmacist may receive verbal orders for medication from a medical care provider. The licensed nurse shall ensure that all verbal orders are signed by the medical care provider within seven working days of receipt of the verbal order. (f) Standing orders. Only a licensed nurse shall make the decision for implementation of standing orders for specified medications and treatments formulated and signed by the resident ' s medical care provider. Standing orders of medications shall not include orders for the administration of	S5310		

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S5310	Continued From page 24 schedule II medications or psychopharmacological medications. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (e) The facilty reported a census of 7 residents and medication management for all 7 residents. Based on record review and interview the operator failed to ensure the licensed nurse obtained the medical care provider's signature on a verbal order within 7 working days of receipt of the order for 1 of 3 sampled residents (#729). Findings included: - Record review for resident #729 on 09/01/2020 at 10:25 AM revealed an admission date of 06/12/2020 with diagnoses of cerebral infarct without residual, dementia without behaviors, hypertension, cognitive communication deficit and anemia. The admission functional capacity screen dated 06/12/2020 identified the resident with impaired cognition in all aspects and could not manage her own medications or treatments. The negotiated service agreement (ALIS Resident Evaluation) dated 06/12/2020 included staff services for medication management. The individual service plan dated 06/12/2020 directed staff the resident was dependent for medications.	S5310		

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S5310	Continued From page 25 Review of the medical care provider's orders revealed a verbal/fax order by licensed nurse C on 06/12/2020 without a medical care provider's signature within 7 days as required. The order included the following: resident diet to have a regular soft diet and a full code. Medications ordered are: Absorbic Acid 500 milligrams (mg) by mouth (PO) daily, cholecalciferol tab 1000 unit PO daily, Ferrous sulfate 325 mg PO daily, Norco 7.5/325 mg twice daily for 3 days, then change to 1 tab Norco by mouth every 6 hours for as needed (PRN) pain, MiraLAX 17 Grams by mouth daily, Prosource liquid 30 cubic centimeters (cc) by mouth daily, Tylenol 325 mg by mouth give 2 tabs twice daily, voltaren gel apply 2 Grams three times daily for pain. Activity as tolerated, physical /occupational therapy of choice, and may crush medications. Interview on 09/02/2020 at 11:39 AM with licensed nurse C confirmed the verbal order lacked a signature by the medical care provider within 7 days of obtaining the order. The operator failed to ensure the licensed nurse obtained the medical care provider's signature on a verbal order within 7 working days of receipt of the order for 1 of 3 sampled residents (#729).	S5310		
S5313 SS=E	26-42-205 (g) (3) Over the counter medication (g) (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	S5313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S5313	Continued From page 26	S5313		

be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container.

This REQUIREMENT is not met as evidenced by:
KAR 26-42-205 (g) (3)

The facility reported a census of 7 residents. Based on observation, staff interview and record review the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on over the counter (OTC) medications and failed to write the name on both the original manufacturer's package of OTC and the container, bottle, or tube which could be removed from the original package. This deficient practice affected residents #413, #623, and #879.

Findings included:

- On 08/31/2020 operator B provided a resident roster which identified the facility managed medications for all 7 residents.

On 08/31/2020 at 2:05PM licensed nurse C opened the only medication cart for inspection. Observation revealed the cart contained several OTC medications for several residents. The following mediations were not labeled with the resident's full name: an open box with an open bottle of clear eyes drops and neither the box or the bottle of eye drops had a resident name and licensed nurse C said it belonged to resident #879. An open bottle of Milk of magnesia without a resident name and licensed nurse C stated t

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S5313	Continued From page 27	S5313		

belonged to resident #413. An open bottle of extra strength antacid labeled with resident #879's initials and licensed nurse C said they belonged to resident #879. The bottom drawer of the cart had single use enemas (2 boxes of 2 each with 1 gone) and not labeled with a resident's name. Licensed nurse C said the enemas belonged to resident #623.

Interview 08/31/2020 at 2:10 PM with licensed nurse C confirmed all OTC medications should be labeled with the resident's first and last name, and if the container can be removed from the manufactures packaging the container should be labeled with the resident's first and last name also.

The facility's undated policy titled ordering and labeling of medications directed licensed staff shall be responsible for the receipt of all OTC drugs delivered to the facility in their original, unbroken manufacturer's package. The pharmacist or licensed nurse shall place the full name of the resident on the package. If the OTC drugs are removed from the original manufacturer's package, other than for administration, the pharmacist shall label the drug as required for prescription drugs.

The operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on over the counter (OTC) medications and failed to write the name on both the original manufacturer's package of OTC and the container, bottle, or tube which could be removed from the original package. This deficient practice affected residents #413, #623, and #879.

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	B087137	A. BUILDING: _____ B. WING _____	C 09/03/2020

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S5335	Continued From page 28	S5335		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437 (a) The facility reported a census of 7 residents. The resident roster identified all 7 residents as cognitively impaired. Based on observation, interview and record review the operator failed to ensure the home was maintained to protect the health and safety of the residents, personnel and the public by a failure to properly store oxygen cylinder tank and ensure the basement door remained locked at all times. This deficient practice had the potential to affect all residents and all staff. Findings included: - During the initial tour on 08/31/2020 at 1:32 PM observation revealed the entry door to the basement from the kitchen area opened freely. The door had a locking mechanism which failed to be engaged. Upon going down the stairs running water could be heard and a musty/moldy odor permeated. The stairs ended into a room full of various equipment (wheelchairs, walkers, chairs and other items). The next room was set	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087137	A. BUILDING: _____ B. WING _____	C 09/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS OF WICHITA LLC	6311 E MARJORIE ST WICHITA, KS 67208

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S5335	Continued From page 29	S5335		

up like a kitchen but had not been used as a kitchen in quite some time. From the ceiling water poured down from the room directly above (the laundry room). The floor had standing water and the room was partially deconstructed with debris all about. The next room had boxes of various items stored on the floor, paint, other equipment and in general disarray. Two metal file cabinets were in 1 room and operator B reported no resident files were stored downstairs but later confirmed the file cabinets did have resident records in them from the previous owner.

Interview on 08/31/2020 at 1:32 PM with operator B confirmed an expectation for the basement door to be locked at all times for resident safety. She confirmed all the residents were cognitively impaired and could be independently mobile.

Also, during the initial tour on 08/31/2020 at 1:32 PM observation revealed a single unsecured oxygen cylinder tank stood on the floor along the wall next to the patio exit.

On 08/31/2020 at 2:40 PM operator B confirmed the oxygen needed to be in a stand and secured to prevent the tank from falling over, being damaged and becoming a projectile.

The operator failed to ensure the home was maintained to protect the health and safety of the residents, personnel and the public by a failure to properly store oxygen cylinder tank and ensure the basement door remained locked at all times. This deficient practice had the potential to affect all residents and all staff.