STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087046S	A. BUILDING: _____ B. WING _____	C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK WEST PLAZA	505 N MAIZE ROAD WICHITA, KS 67212

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S 000	INITIAL COMMENTS The following citations represent the findings of Complaint Investigation # 148284.	S 000		
S 260 SS=D	28-39-150(a) RESIDENT BEHAVIOR Resident behavior and nursing facility practices (a) Restraints. The resident shall be free from any physical restraints imposed or psychopharmacologic drugs administered for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: The facility had a census of 25 residents with 3 residents included in the sample for restraint usage. Based on observation, interview, and interview the facility failed to ensure Resident (R)1 remained free from physical restraints when certified medication aide (CMA) T used a gait belt to secure R1 to her wheelchair. Findings included: - Review of the "Physician's Progress Note" dated 09/30/19 revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion) and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition). Review of the Quarterly "Minimum Data Set" (MDS) dated 11/26/19 revealed the resident had severe impairment for daily decision making. The resident exhibited continuous inattention and disorganized thinking. The resident had physical	S 260		

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

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S 260	Continued From page 1	S 260		

behavioral symptoms directed towards others and rejection of cares, which occurred between one and three days during the seven-day review period. R1 required extensive assistance of one staff member for toileting and limited assistance of one staff member for transferring and walking in her room/corridor.

Review of the "Care Plan" dated 11/27/19 revealed the resident had a cognitive deficit and impaired decision making. The staff allowed the resident ample time to absorb and respond to information, avoided changes in her environment, and provided reorientation as needed (PRN). The staff distracted the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television (TV), or books.

Review of Certified Medication Aide (CMA) T's signed/notarized "Witness Statement Form" dated 12/06/19 revealed on 12/03/19 CMA S assisted R1 to the restroom, into her nighttime clothing, and placed her in the commons area to watch TV. Staff T stated she gave R1 a shower with CMA M and then laid the resident in bed and completed her shift.

Review of a CMA M's signed/notarized "Witness Statement Form" dated 12/06/19 revealed she went outside to smoke when CMA T advised her, and she placed a gait belt around R1 to secure her to the wheelchair. CMA M advised CMA T to remove the gait belt. When CMA T went back inside, CMA M followed her and noted there was not a gait belt on the resident.

Review of Certified Nurse Aide (CNA) N's signed/notarized "Witness Statement Form" dated 12/06/19 revealed on 12/03/19 at approximately 06:15 PM revealed the resident

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was "really antsy" and attempted to get out of her wheelchair. CNA N heard CMA T tell the resident to sit down. CNA N stated she then saw CMA T walk into a resident's room and obtain a gait belt. CNA N stated she left the area to attend to another resident and upon her return she noted a gait belt "wrapped around" R1 and "attached around the back of the wheelchair." CNA N stated when CMA M and CMA T walked away from R1 and began showers for other residents, CNA N and CMA S proceeded to undo R1's gait belt. When CMA T noted the resident's gait was undone, she yelled "shhh" to CNA N. Both CNA T and CNA M left the facility at 08:00 PM, then CNA N and CNA S advised Licensed Nurse (LN) H of the situation. LN H stated she would tell Administrative Nurse D in a "couple of days".

Review of CMA S's undated, signed/notarized "Witness Statement Form" revealed at approximately 06:00 to 07:00 PM staff informed her R1 had a gait belt "wrapped and strapped" around her midsection and to her wheelchair. CNA M removed the gait belt from the resident. CMA S notified LN H of the incident.

Review of LN H's signed/notarized "Witness Statement Form" dated 12/06/19 revealed at approximately 08:15 PM CNA N and CNA S reported a "situation", which occurred earlier in the shift. They reported CMA M and CMA T "tied" R1 to her wheelchair with the "use of a gait belt". CMA S reported she removed the gait belt and CNA N confirmed the resident no longer had a gait belt on. LN H stated she advised CNA N and CNA S she needed to be informed of such allegations at the time of the incident and not later.

An observation of R1 on 12/10/19 at 03:31 PM

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revealed the resident walked, assisted with a gait belt, and did not appear in any distress or have any signs of fear on her face or through her actions.

An interview with CMA S on 12/10/19 at 03:12 PM revealed she observed R1 in her wheelchair with a gait belt around her. CMA S reported she never saw a resident secured in her wheelchair with a gait belt before. CMA S stated R1 stood up and down from her wheelchair, which was her normal behavior, but if staff took the resident to the bathroom that would help with her behaviors.

Interview with CMA M on 12/10/19 at 04:26 PM revealed on 12/03/19 CMA T reported she secured a gait belt around R1 to try and prevent her from falling because she tried to get up from her wheelchair. CMA T told CMA M the gait belt was loose so it would not restrict her.

An interview with LN H on 12/10/19 at 04:36 PM revealed on 12/03/19 two staff members reported seeing two other aides securing the resident to her wheelchair. LN H did not see the resident secured with a gait belt and reported she performed a skin assessment and did not find any bruising or skin irritation. The resident had no difficulties or changes in behavior during the remaining of the shift.

During an interview with Administrative Nurse D on 12/10/19 at 01:32 PM confirmed CMA T then advised her CMA M of secured R1 with a gait belt and CMAT advised her to undo it. Administrative Nurse D reported staff restrained R1 for approximately two minutes and per staff reports she did not try to rise up from her chair or appear in any distress.

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S 260	Continued From page 4 Review of an undated policy entitled "Abuse, Neglect, Exploitation General Policy", revealed the staff would not use verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion. The facility failed to ensure staff did not involuntary restrain R1 with the use of a gait belt, when they secured her to her wheelchair to prevent her from rising.	S 260		
S 295 SS=F	28-39-150(d) STAFF TREATMENT OF RESIDENTS (d) Staff treatment of residents. Each facility shall develop and implement written policies and procedures that prohibit abuse, neglect, and exploitation of residents. The facility shall: (1) Not use verbal, mental, sexual, or physical abuse, including corporal punishment, or involuntary seclusion; (2) not employ any individual who has been identified on the state nurse aide registry as having abused, neglected, or exploited residents in an adult care home in the past; (3) ensure that all allegations of abuse, neglect, or exploitation are investigated and reported immediately to the administrator of the facility and to the Kansas department of health and environment; (4) have evidence that all alleged violations are thoroughly investigated, and shall take measures to prevent further potential abuse, neglect and exploitation while the investigation is in progress;	S 295		

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S 295	Continued From page 5 (5) report the results of all facility investigations to the administrator or the designated representative; (6) maintain a written record of all investigations of reported abuse, neglect, and exploitation; and (7) take appropriate corrective action if the alleged violation is verified. This REQUIREMENT is not met as evidenced by: The facility had a census of 25 residents. Based on observation, interview, and record review the facility failed to ensure staff immediately reported an allegation of abuse to facility administration in a timely manner when a staff member secured Resident (R) 1 to a wheelchair with a gait belt for approximately one minute. The facility further failed to ensure staff checked the nurse aide registry prior to certified medication aide (CMA) staff M providing care to residents. Findings included: - Review of Certified Nurse Aide (CNA) N's signed/notarized "Witness Statement Form" dated 12/06/19 revealed on 12/03/19 at approximately 06:15 PM revealed the resident was "really antsy" and attempted to get out of her wheelchair. CNA N heard CMA T tell the resident to sit down. CNA N stated she then saw CMA T walk into a resident's room and obtain a gait belt. CNA N stated she left the area to attend to another resident and upon her return she noted a gait belt "wrapped around" R1 and "attached around the back of the wheelchair." CNA N stated	S 295		

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when CMA M and CMA T walked away from R1 and began showers for other residents, CNA N and CMA S proceeded to undo R1's gait belt. When CMA T noted the resident's gait was undone, she yelled "shhh" to CNA N. Both CNA T and CNA M left the facility at 08:00 PM, then CNA N and CNA S advised Licensed Nurse (LN) H of the situation. LN H stated she would tell Administrative Nurse D in a "couple of days".

Review of CMA S's undated, signed/notarized "Witness Statement Form" revealed at approximately 06:00 to 07:00 PM staff informed her R1 had a gait belt "wrapped and strapped" around her midsection and to her wheelchair. CNA M removed the gait belt from the resident. CMA S notified LN H of the incident, later in the evening.

Review of LN H's signed/notarized "Witness Statement Form" dated 12/06/19 revealed at approximately 08:15 PM CNA N and CNA S reported a "situation", which occurred earlier in the shift. They reported CMA M and CMA T "tied" R1 to her wheelchair with the "use of a gait belt". CMA S reported she removed the gait belt and CNA N confirmed the resident no longer had a gait belt on. LN H stated she advised CNA N and CNA S she needed to be informed of such allegations at the time of the incident and not later.

During an interview with Administrative Nurse D on 12/10/19 at 01:32 PM confirmed CMA T then advised her CMA M secured R1 with a gait belt and CMA T advised her to undo it. Administrative Nurse D reported staff restrained R1 for approximately two minutes and per staff reports R1 did not try to rise up from her chair or appear in any distress. Administrative Nurse D stated she

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S 295	Continued From page 7 did not know of the incident until 12/04/19 at approximately 04:00 PM. The facility immediately suspended staff involved and started the investigation. The facility provided training to all staff over the abuse, neglect, and exploitation policy. Review of an undated policy entitled "Abuse, Neglect, Exploitation General Policy" revealed the staff would report immediately any suspicion of Abuse, Neglect, or Exploitation to the health service administrator or his/her designee. The facility failed to ensure staff reported an allegation of abuse in a timely manner. - Review of the "Kansas Nurse Aide Registry Check Form" dated 01/25/19 facility for Certified Medication Aide M revealed she did not have a negative finding on her CMA certification. The facility hired CMA M on 01/02/19 and she provided resident care prior to 01/25/19, when the facility verified her CMA certification through the registry. During an interview with Administrative Staff A on 12/10/19 at 04:27 PM revealed the facility identified they had an issue regarding the timeliness of the checks for the registry and/or licensure and reorganized who would be required to perform the task. Review of the undated policy entitled "Abuse, Neglect, Exploitation General Policy" revealed the facility would not employ individuals who had a finding of abuse, neglect, mistreatment of elders, or misappropriation of elder's property entered in the Kansas Nurse Aide Registry.	S 295		

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S 295	Continued From page 8 The facility failed to ensure CMA M did not have a negative finding listed on her certification prior to providing resident care.	S 295		