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 _____	11/22/2019

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 a Health Licensure Resurvey.	S 000		
S 435 SS=D	28-39-152(i)(2) ACCIDENTS (2) Each resident receives adequate supervision and assistive devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility census totaled 26, with three residents sampled for accidents. Based on observation, interview, and record review the facility failed to transfer Resident (R) 2 in a safe manner, when staff incorrectly used a gait belt to transfer the resident from a recliner in a common area of the facility to her wheelchair. Findings included: - Review of R2's "Paper Medical Record" revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). Review of the Annual "Minimum Data Set" (MDS) assessment dated 08/29/19 revealed the resident had a Brief Interview for Mental Status (BIMS) score of two, which indicated severely impaired cognition. The resident required limited assistance of one staff for transfers. The resident had 2 non-injury and 1 non-major injury fall since the last assessment. Review of the Falls "Care Area Assessment" (CAA) dated 08/30/19 revealed the resident	S 435		

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required assistance with Activities of Daily Living (ADLs) due to memory impairment and weakness. The resident attempted to walk (unassisted) at times and used a wheelchair for mobility.

Review of the ADL CAA dated 08/30/19 revealed the resident had a fall since the last assessment and continued to be a fall risk.

Review of the resident's care plan dated 08/30/19 revealed the resident had a risk for falls. Staff would promote the safety of the resident.

Observation of a transfer at 08:13 AM 11/22/19 revealed Certified Nurse Aide (CNA) H transferred R2 from a recliner in the commons area of the facility to her wheelchair. R2 had a loose gait belt in place as CNA H placed her hands under R2's arms and around her body to stand the resident up. When the resident stood up from a sitting position, she made a moaning noise and her legs appeared weak and shaky. CNA H continued the transfer without holding on to the gait belt, with arms wrapped around the resident. The resident's shirt raised up during the transfer, which exposed the resident's back and breast in the commons area of the facility and potentially within view of other residents, visitors, and staff. An unidentified hospice nurse walked over to CNA H during the transfer and reported the resident's exposed skin and tried to lower the resident's shirt before R2 sat in the wheelchair.

An interview with CNA H at 01:13 PM on 11/22/19 revealed she would go to the facility nurses to find out what care to provide residents who lived at the facility. CNA H would use a gait belt with a resident who required assistance for transfers. CNA H stated gait belt use with residents was a

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S 435	Continued From page 2 "must" because sometimes the residents became dizzy. If a resident had weakness, she would sit them back down, touch their back and ask them if everything was ok. CNA H stated the facility provided transfer training. An interview with Administrative Nurse D at 04:58 PM on 11/22/19 revealed she expected staff to place a tightened gait belt on a resident during a transfer and use the gait belt correctly during the transfer. Administrative Nurse D would not expect staff to place their arms around the resident without using the gait belt for a transfer from a recliner to a wheelchair. Administrative Nurse D expected staff to ensure staff did not expose resident skin during a transfer. Review of the facility policy "Mobility Assistance" dated 07/01/12 revealed the facility would offer residents the kind and amount of assistance the resident needed. Staff would be trained in safe transfers, including the use of gait belts. The facility failed to transfer Resident (R) 2 in a safe manner, when staff incorrectly used a gait belt to transfer the resident from a recliner in a common area of the facility to her wheelchair.	S 435		
S 465 SS=D	28-39-153(a) QUALITY OF LIFE Quality of life. Each nursing facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. (a) Dignity. Each facility shall promote respect of each resident and shall fully recognize each resident's individuality.	S 465		

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S 465	Continued From page 3 This REQUIREMENT is not met as evidenced by: The facility census totaled 26, with four residents sampled for dignity. Based on observation, interview, and record review the facility failed to ensure Resident (R) 3 and R4 were treated with dignity by the failure to ensure residents were not sleeping at their dining table for an extended period of time (approximately 30 minutes), waiting on a meal, and within view of other residents and visitors to the facility. During the same dining observation staff placed shirt protectors on residents without asking or letting them know what they were going to do. The facility further failed to ensure staff treated R2 with dignity by allowing her shirt rise during a transfer, which exposed her back and breast in the common area of the facility and within the potential view of other residents and visitors. Findings included: - Observation on 11/22/19 at 8:02 AM revealed R3 and R4 at separate tables, slept in the main dining room of the facility. The residents had no food at the time of the observation. Certified Nurse Aide (CNA) and Licensed Nurse (LN) staff in the area did not engage the residents. Further observation of both residents on 11/22/19 at 8:10 AM revealed R3 and R4 continued to sleep at the dining table, with no food, and no staff interaction. Observation of a transfer at 08:13 AM on 11/22/19 revealed Certified Nurse Aide (CNA) H transferred R2 from a recliner in the commons	S 465		

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S 465	Continued From page 4	S 465		

area of the facility to her wheelchair. The resident's shirt raised up during the transfer, which exposed the resident's back and breast in the commons area of the facility and potentially within view of other residents, visitors, and staff. An unidentified hospice nurse walked over to the CNA during the transfer and reported the resident's exposed skin and tried to lower the resident's shirt before she sat in the wheelchair.

Further observation of both residents on 11/22/19 at 8:15 AM revealed R3 and R4 continued to sleep at the dining table, with no food, and no staff interaction.

An Observation of CNA staff H at 8:22 AM on 11/22/19 revealed she walked up behind a resident and placed a shirt protector on the resident without asking the resident if he/she wanted a shirt protector or letting the resident know what she planned to do.

An observation on 11/22/19 at 8:24 AM revealed R3 and R4 continued to sleep at the dining table, when laboratory services arrived to work with R4. R3 leaned way over the dining table and remained asleep at 8:25 AM and the staff present in the area walked by and no one attempted to engage the resident.

Observation of R3 and R4 on 11/22/19 at 8:30 AM revealed R3 and R4 continued to sleep at the dining table with no staff engagement and no food present.

An interview with CNA H at 01:13 PM on 11/22/19 revealed she would go to the facility nurses to find out what care to provide residents who lived at the facility. CNA H would use a gait belt with a resident who required assistance for transfers

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S 465	Continued From page 5 and tried to keep clothing down during use of a gait belt. CNA H stated all residents required shirt protectors because they might have an accident. CNA H said she would put shirt protectors on all residents, so they were neat and synchronized. CNA H stated she would wake residents up if they were sleeping at the dining table, so they did not sleep on an empty stomach. An interview with Administrative Nurse D at 4:58 PM on 11/22/19 revealed she expected staff to ensure residents were transferred with a tightened gait belt and staff attentive to the resident's clothing during the transfer. Administrative Nurse D further expected staff to offer sleeping residents the opportunity to go back to bed, encourage them to eat, and/or have food ready to eat at meal times. Review of the "Personal Care Services" policy dated 07/01/12 revealed the facility would provide assistance to residents in such a manner as to promote dignity, autonomy, and independence. The facility failed to ensure all residents were treated with dignity. (R2, R3, R4 and other residents during dining observation).	S 465		
S 640 SS=E	28-39-158(g) SANITARY CONDITIONS (2) The facility shall store, prepare, display, distribute, and serve foods to residents, visitors and staff under sanitary conditions. (A) The facility shall keep potentially hazardous foods at a temperature of 45oF or 7oC or lower, or at a temperature of 140oF or 60oC or higher. (B) The facility shall provide each mechanically	S 640		

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refrigerated storage area with a numerically scaled thermometer, accurate to +plus or -minus 3oF or 1.5oC, which is located to measure the warmest part of the storage area and is easily readable.

(C) The facility shall keep frozen food frozen and shall store the food at a temperature of not more than OoF.

This REQUIREMENT is not met as evidenced by:
The facilty reported a census of 26 residents with one kitchen located in the Long-Term Care (LTC) Manor House in which staff served the LTC resident meals. Based on observation, interview, and record review the facility failed to ensure staff served food in a sanitary and hygienic manner to prevent cross contamination of items when dietary staff touched food and non-food surfaces throughout the breakfast service and wore the same gloves throughout the observation.

Finding included:

- Observation of the kitchen on 11/22/19 at 08:24 AM revealed Dietary Staff (DS) B stood behind a functioning steam table with opaque gloves on both of his hands. DS B used his gloved hands to reach into the steam table tub filled with bacon and put the bacon on a plate. DS B then used the same gloved hands to grab eating utensils from behind him and put those with the plate. DS B continued with the same gloved hands and pressed a button on the toaster located behind and to his left to cancel the toasting, and then used his same gloved hands to grab the toast and set it on the white front ledge of the steam

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S 640	Continued From page 7	S 640		

table, grabbed a knife from in front of him and sliced the toast at a diagonal and set the sliced toast on the plate. DS B then used the same gloved hands to grab bread out of an open bag behind him and on the counter, and he then put the two slices bread in the toaster and pressed the lever to begin toasting. At 08:26 AM DS B left the kitchen to deliver a plate of food, came back in with the same gloves on his hands and handed DS G a bowl of oatmeal. DS B continued with the same gloves and grabbed pancakes out of the far left back well of the steam table and used same gloved hands to tear up the pancakes onto a new empty plate he placed on the front ledge of the steam table front. DS B continued to deliver plates to the top of the steam table and grabbed two clean plates at 08:28 AM and used the same gloved hands to tear up pancakes, grabbed bacon and scoops of scrambled eggs, then reached down and grabbed pancake syrup (single serving tubs) and left the kitchen to deliver. DS B used the same gloved hands when he returned to the kitchen at 08:30 AM and walked over to an upper shelf located across from the dirty dishes and sink sprayer and he grabbed a clean mixer container from the upper shelf. DS B then used the same gloved hands to mix up a puree with milk (touching the milk carton and food items he had put into the mixer). At 08:32 AM DS B walked over with the blended substance in the mixer container in his unchanged gloved hand and added hot water from the hot water dispenser into the mixer container and stirred with a spoon and then spooned a mixture over a divided plate filled with food items.

During an interview with DS B on 11/22/19 at 08:35 AM revealed did not think to change his gloves between touching food items and non-food

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S 640	Continued From page 8 items. DS B stated he would start to change gloves now. An interview with Administrative Nurse D at 04:58 PM on 11/22/19 revealed she expected staff to change gloves between touching food and non-food surfaces and/or wash hands. Review of the facility policy regarding dining services with an effective date of 03/18/14 instructed staff "When preparing or serving food, handle all food items as little as possible. If food or utensils must be handled, do so only with clean hands and fingers. Use tongs or scoops for picking up butter, rolls, or ice ..." The policy did not address glove usage during food service. The facility failed to ensure staff served food in a sanitary and hygienic manner to prevent cross contamination of items when dietary staff touched food and non-food surfaces all without changing gloves during the breakfast service.	S 640		
S 835 SS=F	28-39-161 INFECTION CONTROL (5) The facility may choose to wash linens and soiled resident clothing in water at less than 160E F if the following conditions are met: (A) Temperature sensors and gauges capable of monitoring water temperatures to ensure that the wash water does not fall below 72E F are installed on each washing machine. (B) The chemicals used for low temperature washing emulsify in 70E F water. (C) The supplier of the chemical specifies low-temperature wash formulas in writing	S 835		

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S 835	Continued From page 9 for the machines used in the facility. (D) Charts providing specific information concerning the formulas to be used for each machine are posted in an area accessible to staff. (E) The facility ensures that laundry staff receive in-service training by the chemical supplier on a routine basis, regarding chemical usage and monitoring of wash operations. (F) Maintenance staff monitors chemical usage and wash water temperatures at least daily to ensure conformance with the chemical supplier's instructions. This REQUIREMENT is not met as evidenced by: The facility census totaled 26. Based on observation, interview, and record review the facility failed to ensure laundry staff were aware of daily washing machine temperatures and/or made aware of the system the facility used to sanitize resident clothing. Findings included: - Observation of the facility laundry room on 11/22/19 at 08:04 AM with Laundry/Housekeeping (LH) A lacked evidence staff monitored for water temperatures of the washing machines. During an interview on 11/22/19 at 08:04 AM, LH A reported she did not check temperatures of the facility washing machines regularly, but did check the eye station water temperature (located adjacent to the washing machines) weekly. LH A reported chemicals used to launder resident	S 835		

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S 835	Continued From page 10 clothing had built in sanitization, then reported the water temperature also regulated the sanitization of resident clothing. LH Staff A reported the big (industrial machine) should reach 180 degrees Fahrenheit (F), but reported she did not regularly check the machine to ensure it reached the 180-degree F temperature. LH Staff A reported the small (homelike washing) machines would probably require a little lower temperature, although did not express a temperature she would monitor the machine for. LH Staff A reported she washed resident laundry together which is why it was important for the facility sanitize resident clothing. An interview with Administrative Nurse D at 04:58 PM on 11/22/19 revealed she expected LH A to be aware of how the facility sanitized clothing and check water temperatures as required. Review of the facility policy "Housekeeping and Laundry Services" dated 04/01/14 revealed staff would follow necessary infection control precautions when handling and laundering soiled and clean linens. The facility failed to ensure laundry staff were aware of daily washing machine temperatures and/or made aware of the system the facility used to sanitize resident clothing.	S 835		
S1050 SS=D	28-39-162(a) Soiled Work Room (4) Soiled workroom. The facility shall provide a soiled workroom for the disposal of wastes, collection of contaminated material, and the cleaning and sanitizing of resident care utensils. (A) The soiled workroom shall contain a	S1050		

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flushing-rim clinic sink, a work counter, a two-compartment sink, a storage cabinet with a lock for sanitizing solutions and cleaning supplies used in the cleaning of resident care equipment, a covered waste receptacle, and a covered soiled linen receptacle. Any facility constructed before February 15, 1977 shall have a sink.

(B) Minimum room area shall be 80 square feet with a minimum length or width of six feet. Any facility constructed before February 15, 1977 shall not be required to comply with the requirements of this paragraph.

(C) The facility shall not store clean supplies, equipment, and materials in the soiled workroom.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 26. Based on observation, interview, and record review the facility failed to ensure soiled resident clothing were stored in a container, with a lid when laundry staff placed a pile of soiled resident clothing on the floor and up against the outer wall of a washing machine.

Findings included:

- Observation of the facility laundry room on 11/22/19 at 08:04 AM revealed the floor in front of a homestyle type washing machine with a pile of soiled resident clothing on the floor, up against the outer wall of the machine, and outside of any appropriate soiled clothing storage containers.

Further observation of the "Dirty" side of the facility laundry room on 11/22/19 at 08:04 AM

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S1050	Continued From page 12 revealed lidded containers to use for soiled laundry, however a pile of soiled clothing remained on the floor and outside of the containers. During an interview on 11/22/19 at 08:04 AM, Laundry/Housekeeping (LH) A reported she sorted some clothes into the lidded bins in the laundry room, but some she placed on the floor in front of the washers. An interview with Administrative Nurse D at 04:58 PM on 11/22/19 revealed she did not know why laundry staff placed soiled clothing on the floor of the laundry room, but expected staff to place the soiled clothing in the lidded bins provided by the facility. Review of the facility policy "Housekeeping and Laundry Services" dated 04/01/14 revealed staff would follow necessary infection control precautions when handling and laundering soiled and clean linens. The facility failed to ensure soiled resident clothing were stored in a container, with a lid.	S1050		
S1372 SS=E	26-40-305 (i)(1)(2)(3) P E - Preventive maintenance program (i) Preventive maintenance program. Each nursing facility shall have a preventive maintenance program to ensure that all of the following conditions are met: (1) All electrical and mechanical equipment is maintained in good operating condition. (2) The interior and exterior of the building are	S1372		

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S1372	Continued From page 13 safe, clean, and orderly. (3) Resident care equipment is maintained in a safe, operating, and sanitary condition. This REQUIREMENT is not met as evidenced by: The facility census totaled 26. Based on observation, interview, and record review the facility failed to ensure a sanitary environment by the failure to replace air filters on floor vents, which were visibly soiled and failure to clean a ceiling vent in the beauty shop, which had dust debris on it and hanging down. The facility further failed to ensure the facility scale remained clean. Findings included: - An observation on 11/22/19 at 08:39 AM in the facility beauty shop revealed an air vent in the ceiling, very dirty with dust particles all over it and with grey dust particles slightly hanging down from the vent. The facility scale located in the salon had spills on the floor where the residents stood/wheel chairs roll up on. The screen of the digital scale had dust and dried splashes present. The floor vent had a dirty filter grey dust caked all over it. The filter had a candy wrapper stuck to it as it made a moaning noise as air tried to slip through the filter. An observation on 11/22/19 at 8:03 AM of the facility quite room revealed a floor vent with a dirty air filter, which had a large amount of caked on grey dust. An interview with Administrative Nurse D at 4:58 PM on 11/22/19 revealed she expected air vents to be clean and air filters to be clean with no debris collected in the vents.	S1372		

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 _____	11/22/2019

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

(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
S1372	Continued From page 14 Review of the policy "External Environmental Services" dated 04/01/14 revealed the building would be kept in good, safe repair for the enjoyment of residents in the community. The facility failed to ensure a clean, sanitary environment.	S1372		