Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087221	A. BUILDING: _____ B. WING _____	C 10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED CARE HOME PLUS	5501 POLO DRIVE WICHITA, KS 67208

(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 an abbreviated survey for complaints #143158 and #143798 of the above named facility conducted on 10/17/19, 10/21/19 and 10/23/19.	S 000		
S 190 SS=D	26-39-102 (e) Admission, Transfer, Discharge (e) Before a resident is transferred or discharged involuntarily, the administrator or operator, or the designee, shall perform the following: (1) Notify the resident, the resident ' s legal representative, and if known, a designated family member of the transfer or discharge and the reasons; and (2) record the reason for the transfer or discharge under any of the circumstances specified in paragraphs (d) (1) through (4) in the resident ' s clinical record, which shall be substantiated as follows: (A) The resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met by the adult care home; (B) the resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the adult care home; and (C) a physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary because the health or safety of other individuals in the adult care home is endangered.	S 190		

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

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S 190	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-39-102 (e) (1) (2) (A) The facility reported a census of 9 residents. The sample included 3 residents and 1 closed record review. Based on observation, record review and interview the operator failed to ensure the completion of the following steps required for an involuntary discharge for resident #2 who transferred to the hospital and did not return: record the reason for the discharge, documentation by a medical care provider of the rationale for the discharge, and notification of the resident, the resident's legal representative or designated family member of the discharge and reason. Findings included: - Record review on 10/17/19 at 10:12 AM for resident #2 revealed an admission dated of 3/08/17. She had the following medical diagnoses: cerebral vascular accident (stroke) with weakness, chronic obstructive airway disease, chronic kidney disease, hypertension, diabetes mellitus type 2, and obesity. The record included 2 functional capacity screen (FCS), an admission FCS dated 3/08/17 and an annual FCS dated 3/08/18. The annual FCS dated 3/08/18 identified the resident with short and long-term memory deficit, impaired memory recall and impaired decision making. She was unable to perform any of the tasks for bathing, toileting, transfers with physical assistance for dressing, use of a walker, wheelchair and mechanical lift at times. She was totally incontinent of the bladder, unable to manage her	S 190		

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S 190	Continued From page 2	S 190		

own medications/treatments and was at risk for falls.

The negotiated service agreement (NSA) dated 3/08/17 (no evidence of a review for 2018) with an addendum on 1/10/19 included services of meals and snacks based on a liberalized diet. She needed assistance with all activities of daily living (ADLs - bathing, toileting, dressing, incontinence, transfers and mobility). The NSA did not indicate how much assistance (limited, moderate or total) by staff the resident needed for her ADLS. The resident used side rails (1/2 rail) while in bed to promote independence and mobility. She needed assistance of 2 staff to exit the building in an emergency situation and the NSA included the monthly fee based on 2 person assist level of care. The facility would manage her medications, vital signs and blood sugar testing. She received oxygen services from an outside provider and the facility provided weekly laundry and housekeeping services. The NSA did not identify the residents use of a walker, wheelchair and mechanical lift as identified on the FCS.

Review of the resident service plan (RSP) dated 6/07/18 with only 1 revision on 1/10/19 regarding a change to a liberalized diet. The RSP directed staff to provide the resident with assistance to meals, set-up and cut up food. Staff to administer the resident's medications as ordered, blood sugar testing twice a day and as needed for hypoglycemia. Provide oxygen at 2 liter/minute by nasal cannula at night and PRN (as needed) to maintain oxygen saturation greater than 90% with staff checking oxygen saturation every shift. The RSP directed staff the resident required total staff performance of 2 person with dressing/undressing, bathing, toileting and incontinence care with toileting every 2 hours and

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S 190	Continued From page 3	S 190		

PRN. She used a wheelchair and was dependent on staff for wheelchair mobility. She needed 2 staff assistance with a walker for transfers and ambulation short distances advancing ambulation as tolerated. Staff to use a mechanical lift (type not specified) as needed when the resident was unable/willing to stand and transfer. She used a 1/2 rail while in bed to promote independence/mobility and reposition the resident every 2 hours.

Review of the nursing notes (NN) between 11/15/18 and the last entry dated 7/07/19 revealed no changes in the resident's functional status through 3/19/19. Beginning on or about 4/13/19 the resident began having a physical decline with a hospitalization on 5/11/19 for chest pain with slight elevation of troponin (a lab test to indicate heart attack and a return to the facility on 5/20/19. The resident again transferred to the hospital on 6/23/19 for a change in facial coloration and non-responsive episode with a return to the facility on 6/25/19. On 7/05/19 at 7:00 PM licensed nurse E recorded the resident had 2+ edema to bilateral upper and lower extremities ... the nurse notified the medical care provider with orders to obtain lab testing and urinalysis ... orders to administer Lasix (a diuretic) 40 milligrams (mg) by mouth 1 time now and start Lasix 20 mg daily beginning 7/06/19 and potassium 20 milliequivalents daily ...

The next entry dated 7/07/19 (no time) by licensed nurse E - at approximately 7:30 AM (unnamed) certified staff noted the resident with course congestion, gurgling noises and a small amount of red tinged sputum. ... licensed nurse E directed the certified staff to call emergency medical services (EMS) for transportation to a named hospital for evaluation which the medical

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S 190	Continued From page 4	S 190		

care provider had authorized. The resident was transported by EMS and the durable power of attorney followed to the hospital. This was the last entry in the nursing notes.

Review of the medical care provider's written orders revealed no information regarding the resident's status post transport to the hospital by EMS.

Review of the hospitalization record revealed the emergency room report indicated EMS was called on 7/07/19 upon arrival - facility staff reported after giving the resident her medications this morning by mouth the resident had some blood tinged sputum out of her mouth. Staff report prior to her medications the resident had some gurgling noises from the back of her throat. Staff report for the past few days the resident had a decline in health but no complaints of pain or feeling unwell. Resident denies having any difficulty, pain or feeling unwell. Resident is slow to respond when answering questions but will respond.

Emergency room Assessment as follows:
HEENT (head, ears, eyes, nose and throat) - unremarkable
neck - unremarkable
chest - equal chest rise bilateral
abdomen - unremarkable
pelvis - unremarkable
extremities - PMS (pulse/motor/sensory) intact all extremities with equal grip strength and movement
cardiovascular - sinus bradycardia with strong regular radial pulses
no facial drooping or slurred speech
pitting edema 3+
transported to hospital per family request

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S 190	Continued From page 5 The note included - reason for hospitalization - EMS called for increasing weakness, confusion, altered mental status which progressively worsened in the last 3 days. CT scan of brain is negative. Patient being admitted for generalized weakness and edema. Review of radiology reports revealed a chest X-ray dated 7/07/19 revealed Cardiomegaly with no failure, no infiltrates or effusions seen with no focal pneumonia or pulmonary edema. A CT (computer tomography) scan dated 7/07/19 of the head revealed - Axial imaging of the brain without contrast on 7/07/19 and compared to 6/23/19 revealed chronic ischemic changes as well as atrophy. No superimposed acute hemorrhage or infarct appreciated. No mass, mass effect or midline shift. The calvarium is intact. The paranasal sinuses and mastoid air cells appear unremarkable with impression of no acute process, chronic changes as above. An MRI 7/12/19 to rule out stroke revealed no evidence of acute ischemia, age-related global volume loss with mild microvascular changes within the white matter, no evidence of hemorrhage, mass effect or hydrocephalus. No evidence of high-grade intracranial stenosis or large vessel occlusion. Speech therapy evaluated the resident while in the hospital on several visits for dysphagia. Recommendations Puree consistency diet with thin liquids, no straws, patient should be fully alert and upright for all by mouth intakes, small bites and drinks. Review of the documents at the time of discharge and transfer to a skilled long-term care nursing	S 190		

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S 190	Continued From page 6	S 190		

facility on 7/26/19 revealed the resident's status was consistent with prior hospitalization with noted changes in diet consistency, use of oxygen continuously instead of just at night/laying down. She was alert, verbal and oriented to person with anxious/restlessness. Heart sounds regular rhythm and pulses with pink nail beds. Resident noted with 1+ edema of arms, hands, feet with positive pedal pulses. She required total care for all activities of daily living (ADLs) which was not changed from her stay at this home plus facility. She required the use of a total body mechanical lift.

Observation on 10/17/19 at 9:15 AM revealed the resident no longer resided in the facility. Observation on 10/17/19 at 2:08 PM revealed the facility had 2 total body lifts on the back porch. One lift was rated for 400 pounds and the other for 450 pounds. Both lifts were in working order.

Interview on 10/17/19 at 11:25 AM with certified staff C and D revealed January 2019 until about May 1, 2019 the resident required a 2 person assist to transfer and walk short distance with a walker and did not require a mechanical lift. One staff would walk in front with the walker and 1 staff behind with the wheelchair to have it readily available if the resident got tired or weak. She started going downhill in early May 2019 with having trouble getting up in the mornings. At times she really needed 3 people but only have 2. She would have trouble turning to the commode in her room. After the 5/11/19 lowering to the floor the staff began using the sit-to-stand lift. She would have good days and bad days so we asked her how she was feeling and if feeling weak we would use the sit-to-stand lift. After the 5/11/19 lowering to the floor the resident was fearful of falling and afraid to try then she just got weaker

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S 190	Continued From page 7	S 190		

and weaker. During the transfer on 5/27/19 with the sit-to-stand lift they were in the hallway wheeling into the shower room when the resident just went limp with her arms flopping to the side and staff had to lower her to the floor with the help of her significant other who was present at the time. Certified staff C reported being uncomfortable with using the sit-to-stand lift due to the resident's body size and previous incidents. She reported asking licensed nurse E if they could use the total body lift instead but the nurse told them to keep using the sit-to-stand. Certified staff D reported no other means for transfer were tried, the resident was weak and a big lady.

Interview on 10/17/19 at 11:37 AM with licensed nurse B revealed he was not the nurse of record until the beginning of July. He reported being involved in the decision regarding the resident's return to the facility and he felt the resident's condition needed skilled nursing 24/7 care. He reported going to the hospital and speaking with the resident's case manager and explaining why he felt the resident could not return to the home plus. He confirmed the resident's record lacked any documentation of his assessment, his conversation with the case manager, consultation with the resident's medical care provider for rationale of why the resident could not return and no documentation of notification of the resident or the resident's legal representative of the need for involuntary discharge.

Interview with licensed nurse F (hospital staff) on 10/17/19 at 12:30 PM by telephone revealed the resident was hospitalized on 7/07/19 and after course of treatment had returned to her baseline for mental status, ADL function and nursing care needs. She reported speaking with a male nurse to see what the resident's baseline was and the

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S 190	Continued From page 8 nurse reported the resident was 2 assist transfer with a lift. She said the male nurse reported the resident could not bear weight on her legs, so she assumed the lift used at the home plus was a total body lift which meant her care needs were the same at the time the hospital was ready to discharge. She reported a male and female nurse came to the hospital to meet with the resident's care manager and stated they could not meet the resident's care needs. She reported stating to the nurses the resident was at her prior level so why are you unable to meet her care needs now. She reported the resident's significant other said the resident had not walked in a long time and could only stand with assist of 2 staff and a grab bar. She said the nurses told her the home plus did not have a total body lift. Interview on 10/17/19 at 12:59 PM with hospital case manager G revealed she was not the case manager assigned to the resident that case manager is no longer with the hospital, but she participated in the meeting with the home plus facility staff and helping the other case manager find another placement for the resident. She reported reading from the other case managers notes in the resident's record - on the morning of the discharge she spoke with licensed nurse E about the resident being ready to discharge back to the facility and was told the facility could take her back, confirmed she was at baseline with a Hoyer (total body lift) and the facility had one to transfer the resident to the bed. Then a little later licensed nurse E call back and requested the resident go to a skilled nursing facility. Later that day, a female nurse and a male nurse came to the hospital and after much discussion we contacted skilled nursing facility and arranged a discharge with them.	S 190		

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S 190	Continued From page 9	S 190		

Interview on 10/17/19 at 2:27 PM by telephone with licensed nurse E revealed she could not remember if she completed the annual FCS for 2019, she did not remember if she evaluated the resident's transfer abilities/safety after the lowering to the floor episodes on 5/11/19 and 5/27/19. She reported the resident was already care planned for a sit-to-stand lift PRN. She remembered getting a call in the morning of approximately 7/25/19 from the case manager to say the resident was ready to return to the facility. She discussed this with licensed nurse B and then the two of them went to the hospital to meet with the case manager. She reported neither herself or licensed nurse B believed they could meet the care needs of the resident. When asked what care needs were different, she responded the resident now needed oxygen continuous and a BIPAP (a non-invasive therapy for treatment of sleep apnea) machine when sleeping. She said the hospital reported the resident needed a total body lift which was more care than needed before.

Interview on 10/17/19 at 3:15 PM with licensed nurse/operator A revealed he deferred the decision of being able to take the resident back to licensed nurse B. He confirmed the record lacked documentation of the reason the resident's needs could not be met, a medical care provider's documentation of the rationale for the involuntary discharge and notification of the resident or resident's legal representative.

Interview on 10/21/19 at 9:26 AM with medical care provider H revealed the resident admitted to the long-term care (LTC) facility on 7/26/19 for skilled nursing and therapy services. She reported the resident was not unstable or in any acute state at the time of discharge from the

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S 190	Continued From page 10	S 190		

hospital to the LTC facility. She reported the resident needed total care and a total body lift for transfers.

The facility's undated policy/procedure titled, Admission/Transfer/Discharge directed staff the operator shall ensure that each resident was permitted to remain in the home plus and was not transferred or discharged from the home plus unless one of the following conditions was met:
Transfer or discharge was necessary for the resident's welfare and the resident's needs cannot be met in the current home plus.
The safety of the other individuals at the home plus was endangered
The health of other individuals at the home plus was endangered
The resident had failed, after reasonable and appropriate notice, to pay the rates and changes of the home plus.

Before a resident is transferred or discharged involuntarily, the operator or his/her designee shall perform the following:
Notify the resident, the resident's legal representative and if known, a designated family member of the transfer or discharge and the reasons.
Record the reason for the transfer or discharge under any of the circumstances specified in paragraph (d) 1 through 4 (as stated above) in the resident's clinical record, which shall be substantiated as follows:
The resident's medical care provider shall document the rationale for the transfer or discharge in the resident's clinical record if the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met at the home plus.

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S 190	Continued From page 11 The operator failed to ensure the completion of the following steps required for an involuntary discharge for resident #2 who transferred to the hospital and did not return: record the reason for the discharge, documentation by a medical care provider of the rationale for the discharge, and notification of the resident, the resident's legal representative or designated family member of the discharge and reason.	S 190		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201 (c) The facility reported a census of 9 residents. The sample included 3 residents and 1 closed record review. Based on record review and interview the operator failed to ensure designated staff conducted a screening to determine 1 of 4 (#2) resident's functional capacity at least once every 365 days. Findings included: - Record review on 10/17/19 at 10:12 AM for	S5085		

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S5085	Continued From page 12	S5085		

resident #2 revealed an admission date of 3/08/17. She had the following medical diagnoses: chronic obstructive airway disease, chronic kidney disease, hypertension, diabetes mellitus type 2, and obesity.

The record included 2 functional capacity screen (FCS), an admission FCS dated 3/08/17 and an annual FCS dated 3/08/18. The annual FCS dated 3/08/18 identified the resident with short and long-term memory deficit, impaired memory recall and impaired decision making. She was unable to perform any of the tasks for bathing, toileting, transfers with physical assistance for dressing, use of a walker, wheelchair and mechanical lift at times. She was totally incontinent of the bladder, unable to manage her own medications/treatments and was at risk for falls.

Review of the nursing notes between 11/15/18 and 5/16/19 revealed the resident remained a resident of the facility without a hospital stay, therapeutic leave or discharge.

Interview on 10/17/19 at 11:35 AM with licensed nurse B confirmed the record lacked an annual FCS for 2019.

The undated facility policy/procedure titled, Resident Functional Capacity Screening directed the operator or designated staff to conduct a screening to determine each resident's functional capacity at least once every 365 days.

The operator failed to ensure designated staff conducted a screening to determine this resident's functional capacity at least once every 365 days.

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S5155	Continued From page 13	S5155		
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 by: KAR 26-42-204 (a) The facility reported a census of 9 residents. The sample included 3 residents and 1 closed record review. Based on record review and interview licensed nurse/operator A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for 1 of 4 sampled residents (#2) in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review on 10/17/19 at 10:12 AM for resident #2 revealed an admission date of 3/08/17. She had the following medical diagnoses: cerebral vascular accident (stroke) with weakness, chronic obstructive airway disease, chronic kidney disease, hypertension, diabetes mellitus type 2, and obesity. The record included 2 functional capacity screen	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087221	A. BUILDING: _____ B. WING _____	C 10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED CARE HOME PLUS	5501 POLO DRIVE WICHITA, KS 67208

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S5155	Continued From page 14	S5155		

(FCS), an admission FCS dated 3/08/17 and an annual FCS dated 3/08/18. The annual FCS dated 3/08/18 identified the resident with short and long-term memory deficit, impaired memory recall and impaired decision making. She was unable to perform any of the tasks for bathing, toileting, transfers with physical assistance for dressing, use of a walker, wheelchair and mechanical lift at times. She was totally incontinent of the bladder, unable to manage her own medications/treatments and was at risk for falls.

The negotiated service agreement (NSA) dated 3/08/17 (no evidence of a review for 2018) with an addendum on 1/10/19 included services of meals and snacks based on a liberalized diet. She needed assistance with all activities of daily living (ADLs - bathing, toileting, dressing, incontinence, transfers and mobility). The NSA did not indicate how much assistance (limited, moderate or total) by staff the resident needed for her ADLs. The resident used side rails (1/2 rail) while in bed to promote independence and mobility. She needed assistance of 2 staff to exit the building in an emergency situation and the NSA included the monthly fee based on 2 person assist level of care. The facility would manage her medications, vital signs and blood sugar testing. She received oxygen services from an outside provider and the facility provided weekly laundry and housekeeping services. The NSA did not identify the residents use of a walker, wheelchair and mechanical lift as identified on the FCS.

Review of the resident service plan (RSP) dated 6/07/18 with only 1 revision on 1/10/19 regarding a change to a liberalized diet. The RSP directed staff to provide the resident with assistance to meals, set-up and cut up food. Staff to administer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087221	A. BUILDING: _____ B. WING _____	C 10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED CARE HOME PLUS	5501 POLO DRIVE WICHITA, KS 67208

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S5155	Continued From page 15	S5155		

the resident's medications as ordered, blood sugar testing twice a day and as needed for hypoglycemia. Provide oxygen at 2 liters by nasal cannula at night and PRN (as needed) to maintain oxygen saturation greater than 90% with staff checking oxygen saturation every shift. The RSP directed staff the resident required total staff performance of 2 person with dressing/undressing, bathing, toileting and incontinence care with toileting every 2 hours and PRN. She used a wheelchair and was dependent on staff for wheelchair mobility. She needed 2 staff assistance with a walker for transfers and ambulation short distances advancing ambulation as tolerated. Staff to use a mechanical lift (type not specified) as needed when the resident was unable/willing to stand and transfer. She used a 1/2 rail while in bed to promote independence/mobility and reposition the resident every 2 hours.

Review of the nursing notes (NN) between 11/15/18 and the last entry dated 7/07/19 revealed no changes in the resident's functional status through 3/19/19. On 4/13/19 the resident reported having increased discomfort in her bilateral lower extremities with the medical care provider (MCP) consulted and ordered pain medication. On 4/23/19 had elevated blood pressure with MCP notified and medication adjustment. On 5/01/19 urine sample obtained for testing due to odorous urine and frequency. On 5/03/19 the MCP ordered an antibiotic to treat a urinary tract infection. An entry dated 5/11/19 which read - at approximately 6:20 AM the resident was being assisted up for breakfast x 2 staff, the resident took a couple of steps with the walker and started leaning forward. Staff assisted the resident to the floor ... emergency medical services (EMS) was contacted for assistance to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087221	A. BUILDING: _____ B. WING _____	C 10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED CARE HOME PLUS	5501 POLO DRIVE WICHITA, KS 67208

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S5155	Continued From page 16	S5155		

get the resident off the floor due to resident's heaviness ... MCP was notified and gave order to use the sit to stand mechanical lift PRN for general weakness. The resident has a history of arthritic bilateral knees. On 5/13/19 at 5:00 PM resident noted with increased discomfort to bilateral knees, MCP notified with a request for X-rays of the knees and order received. On 5/14/19 at 11:00 AM results of the bilateral knee X-ray revealed no evidence of a fracture or dislocation involving the right knee, no acute osseous abnormality in right knee, osteoarthritic changes, soft tissue swelling is seen throughout the lower thigh and upper calf. Results faxed to MCP. The nursing notes did not include any assessment of the resident with safety during transfers.

NN dated 5/16/19 (no time) - at approximately 11:00 AM the resident reported having some pain in her right upper chest and mid sternal area, vital signs listed, MCP notified with orders to transport to hospital emergency room for evaluation ... At approximately 11:50 AM the resident transported by EMS to (named) hospital for evaluation. The next entry dated 5/20/19 at 4:00 PM - resident readmitted to the facility from hospital with same diagnoses listed and per report from the hospital licensed nurse the resident had a slight elevation of troponin (a lab test to indicate heart attack). The resident is alert and able to make needs known with some intermittent forgetfulness (confusion) at times with some impaired decision making at times. She had trace edema in bilateral extremities ... required extensive assist of 2 staff for ADLs and transfers, intermittent occasional incontinence of bowel and bladder at times, uses a commode in her room. On 5/21/19 the resident voiced to the MCP some signs/symptoms (S/S) of anxiousness with medication ordered to treat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087221	A. BUILDING: _____ B. WING _____	C 10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED CARE HOME PLUS	5501 POLO DRIVE WICHITA, KS 67208

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S5155	Continued From page 17 these S/S. NN dated 5/27/19 (no time) - at approximately 6:35 AM 2 staff were assisting the resident to the shower with a sit-to-stand mechanical lift. The resident had to be lowered to the floor possibly due to generalized weakness to bilateral lower extremities, no injures noted at this time ... The note lacked a nursing assessment of the resident's ability/safety to use the sit-to-stand lift with weak knees (a sit-to-stand lift requires the ability to use the legs and bear weight on the legs) and a new medication for anxiety (possible side effects of dizziness and drowsiness). On 5/28/19 at 1:00 PM the resident noted with increased anxiousness/restless and insomnia with MCP notified and anxiety medication increased and addition of melatonin for sleep. NN dated 6/05/19 at 4:00 PM received new orders from MCP due to resident noted with S/S of discomfort bilateral knee area, Oxycodone 5 milligrams by mouth every 6 hours PRN for moderate to severe pain. The record lacked any nurse assessment of the resident's ability/safety for use of the sit-to-stand lift with the increased pain in bilateral knees. NN dated 6/23/19 (no time) - at approximately 6:15 PM the resident was being assisted to bed by 2 staff when staff noted the resident facial color possible S/S of cyanotic (bluish or purplish discoloration of the skin or mucous membranes due to low oxygen saturation) episode. Vital signs were blood pressure 118/48, pulse 52, oxygen saturation fluctuated between 92-96% on oxygen at 2 liters per nasal cannula ... EMS called and upon arrival informed of brief non-responsible episode with some excess saliva to resident's lips ... EMS transported the resident to the	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087221	A. BUILDING: _____ B. WING _____	C 10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED CARE HOME PLUS	5501 POLO DRIVE WICHITA, KS 67208

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S5155	Continued From page 18	S5155		

emergency room for evaluation. The next entry dated 6/25/19 at 6:10 PM revealed the resident returned to the facility by private vehicle with diagnoses of urinary tract infection and all previous diagnoses. ... ambulate with assist only as tolerated with follow up appointments to MCP as listed. The next entry dated 6/25/19 at 7:00 PM included information about clarification of physician orders, assessment of bruising on the resident's arms, redness in skin folds, 1+ edema bilateral lower extremities ...

The record included chronological entries 5/28/19, 6/05/19, 6/14/19, 6/19/19, 6/21/19, 6/23/19, 6/25/19 with the next entry dated 5/26/19 at 5:30 AM - while changing her - resident was lowered to the floor, (unreadable looks like no then a line crossing it out), EMS was called to get her up from the floor. The resident was very confused and non-responsive at the time. Licensed nurse/operator A sent the resident to the hospital for assessment. The next entry dated 5/26/19 at 10:00 AM - resident back to facility from hospital without any new orders ... The next entry was dated 7/05/19 at 7:00 PM ... Interview on 10/17/19 at 10:30 AM with licensed nurse/operator A revealed he reported the 5/26/19 entry was not a late entry that he had meant the date to be 6/26/19. The NN failed to include details of the lowering to the floor such as how much staff was assisting, how were the staff transferring the resident and whether the resident's transfer abilities/safety were assessed following the incident/accident.

The record included accident/incident reports for the 5/11/19 and 5/27/19 lowering to the floor but none for 5/26/19 (or 6/26/19 if recorded date was incorrect). The 5/11/19 incident report read - resident being assisted out of bed by 2 staff with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087221	A. BUILDING: _____ B. WING _____	C 10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED CARE HOME PLUS	5501 POLO DRIVE WICHITA, KS 67208

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S5155	Continued From page 19	S5155		

a walker, resident taking a couple of steps with the walker/assist then leaned forward and was lowered to the floor. Licensed nurse E recorded an intervention of with increased episodes of general weakness sit-to-stand mechanical lift to be used PRN. The 5/27/19 incident report read - 2 staff members assisted the resident to the shower with a mechanical sit-to-stand lift. Resident noted that she had to be lowered to the floor. The incident report lacked any assessment of the resident's ability/safety with the use of the sit-to-stand lift. Licensed nurse E recorded an interventions of bath times changed to evenings due to mobility noted decreased in the mornings and mobility increases during the day and evening time.

Interview on 10/17/19 at 11:25 AM with certified staff C and D revealed January 2019 until about May 1, 2019 the resident required a 2 person assist to transfer and walk short distance with a walker and did not require a mechanical lift. One staff would walk in front with the walker and 1 staff behind with the wheelchair to have it readily available if the resident got tired or weak. She started going downhill in early May 2019 with having trouble getting up in the mornings. At times she really needed 3 people but only have 2. She would have trouble turning to the commode in her room. After the 5/11/19 lowering to the floor the staff began using the sit-to-stand lift. She would have good days and bad days so we asked her how she was feeling and if feeling weak we would use the sit-to-stand lift. After the 5/11/19 lowering to the floor the resident was fearful of falling and afraid to try then she just got weaker and weaker. During the transfer on 5/27/19 with the sit-to-stand lift they were in the hallway wheeling into the shower room when the resident just went limp with her arms flopping to the side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087221	A. BUILDING: _____ B. WING _____	C 10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED CARE HOME PLUS	5501 POLO DRIVE WICHITA, KS 67208

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S5155	Continued From page 20	S5155		

and staff had to lower her to the floor with the help of her significant other who was present at the time. Certified staff C reported being uncomfortable with using the sit-to-stand lift due to the resident's body size and previous incidents. She reported asking licensed nurse E if they could use the total body lift instead but the nurse told them to keep using the sit-to-stand. Certified staff D reported no other means for transfer were tried, the resident was not non-complaint she was weak and a big lady. Neither certified staff knew of a 3rd lowering to the floor on either 5/26/19 or 6/26/19 (whichever day is correct).

Interview on 10/17/19 at 10:30 AM with licensed nurse/operator A confirmed he did not complete an incident/accident report following the 5/26/19 or 6/26/19 (which ever day the incident occurred) and he failed to assess the resident's transfer abilities/safety.

Interview on 10/17/19 at 11:37 AM with licensed nurse B revealed he was not the nurse of record until the beginning of July. He reviewed the record and confirmed the record lacked any evidence of a nurse assessment/evaluation for the resident's transfer abilities/safety.

Interview on 10/17/19 at 2:27 PM by telephone with licensed nurse E revealed she could not remember if she completed the annual FCS for 2019, she did not remember if she evaluated the resident's transfer abilities/safety after the lowering to the floor episodes on 5/11/19 and 5/27/19. She reported the resident was already care planned for a sit-to-stand lift PRN. She could not comment on what the record included or lacked since she was not able to access the record at this time. She reported being the nurse only part-time in May and June of 2019 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087221	A. BUILDING: _____ B. WING _____	C 10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED CARE HOME PLUS	5501 POLO DRIVE WICHITA, KS 67208

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S5155	Continued From page 21 indicated licensed nurse/operator A was the nurse with oversight. She thought licensed nurse B started as part-time towards the end of June 2019, but she did not remember talking with him before the resident went to the hospital the last time on 7/07/19. Licensed nurse/operator A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for this resident in accordance with the functional capacity screening and the negotiated service agreement.	S5155		
S5251 SS=D	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105 (f) (11) The facility reported a census of 9 residents. The sample included 3 residents and 1 closed record review. Based on record review and interview licensed nurse/operator A failed to ensure 1 of 4 sampled resident's (#2) records included documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, actions taken and results of the actions regarding infections, physical decline/transfer abilities, transfers to hospital and a non-return from the hospital.	S5251		

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	B087221	A. BUILDING: _____ B. WING _____	C 10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED CARE HOME PLUS	5501 POLO DRIVE WICHITA, KS 67208

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S5251	Continued From page 22 Findings included: - Record review on 10/17/19 at 10:12 AM for resident #2 revealed an admission date of 3/08/17. She had the following medical diagnoses: cerebral vascular accident (stroke) with weakness, chronic obstructive airway disease, chronic kidney disease, hypertension, diabetes mellitus type 2, and obesity. The annual functional capacity screening (FCS) dated 3/08/18 identified the resident with short and long-term memory deficit, impaired memory recall and impaired decision making. She was unable to perform any of the tasks for bathing, toileting, transfers with physical assistance for dressing, use of a walker, wheelchair and mechanical lift at times. She was totally incontinent of the bladder, unable to manage her own medications/treatments and was at risk for falls. The negotiated service agreement (NSA) dated 3/08/17 (no evidence of a review for 2018) with an addendum on 1/10/19 included services of meals and snacks based on a liberalized diet. She needed assistance with all activities of daily living (ADLs - bathing, toileting, dressing, incontinence, transfers and mobility). The NSA did not indicate how much assistance (limited, moderate or total) by staff the resident needed for her ADLs. The resident used side rails (1/2 rail) while in bed to promote independence and mobility. She needed assistance of 2 staff to exit the building in an emergency situation and the NSA included the monthly fee based on 2 person assist level of care. The facility would manage her medications, vital signs and blood sugar testing. She received oxygen services from an outside	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087221	A. BUILDING: _____ B. WING _____	C 10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED CARE HOME PLUS	5501 POLO DRIVE WICHITA, KS 67208

(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
S5251	Continued From page 23	S5251		

provider and the facility provided weekly laundry and housekeeping services. The NSA did not identify the residents use of a walker, wheelchair and mechanical lift as identified on the FCS.

Review of the resident service plan (RSP) dated 6/07/18 with only 1 revision on 1/10/19 regarding a change to a liberalized diet. The RSP directed staff to provide the resident with assistance to meals, set-up and cut up food. Staff to administer the resident's medications as ordered, blood sugar testing twice a day and as needed for hypoglycemia. Provide oxygen at 2 liter by nasal cannula at night and PRN (as needed) to maintain oxygen saturation greater than 90% with staff checking oxygen saturation every shift. The RSP directed staff the resident required total staff performance of 2 person with dressing/undressing, bathing, toileting and incontinence care with toileting every 2 hours and PRN. She used a wheelchair and was dependent on staff for wheelchair mobility. She needed 2 staff assistance with a walker for transfers and ambulation short distances advancing ambulation as tolerated. Staff to use a mechanical lift (type not specified) as needed when the resident was unable/willing to stand and transfer. She used a 1/2 rail while in bed to promote independence/mobility and reposition the resident every 2 hours.

Review of the nursing notes (NN) between 11/15/18 and the last entry dated 7/07/19 revealed the following:
On 11/15/18 (no time) which indicated the facility obtained a urine sample, sent for testing and the medical care provider ordered an antibiotic for 7 days to treat the infection. The next note dated 11/16/18 (no time) indicated the resident remained on an antibiotic for urinary tract

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087221	A. BUILDING: _____ B. WING _____	C 10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED CARE HOME PLUS	5501 POLO DRIVE WICHITA, KS 67208

(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
S5251	Continued From page 24	S5251		

infection without adverse reaction with the next note dated 12/17/18. The record lacked a notation of the results post treatment with an antibiotic.

On 4/13/19 the resident reported having increased discomfort in her bilateral lower extremities with the medical care provider (MCP) consulted and ordered pain medication. The record lacked any evaluation of the new medication and whether the resident had less pain over the next 10 days with the next note dated 4/23/19 at 11:30 AM about elevated blood pressure with MCP notified and medication adjustment. The next note dated 4/24/19 (no time) was about lab tests and result with no further mention of the resident blood pressure and the next note dated 5/01/19.

On 5/01/19 urine sample obtained for testing due to odorous urine and frequency. On 5/03/19 the MCP ordered an antibiotic for 7 days to treat a urinary tract infection. The next entry was 5/11/19 with no other entries regarding the results of the antibiotic treatment.

On 7/07/19 (no time) - at approximately 7:30 AM staff noted the resident with course congestion and gurgling noises with a small amount of red tinged sputum with oxygen saturation at 92% on room air. Licensed nurse E informed the staff to call EMS and send to hospital for evaluation which the medical care provider ordered. ... Resident transported by EMS. This was the last entry in the nursing notes.

Interview on 10/17/19 at 11:37 AM with licensed nurse B revealed the resident was admitted to the hospital on 7/07/19 after EMS transported her to the emergency room for evaluation. He confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087221	A. BUILDING: _____ B. WING _____	C 10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED CARE HOME PLUS	5501 POLO DRIVE WICHITA, KS 67208

(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
S5251	Continued From page 25 the record did not reflect this change. He reported the resident did not return to the facility after the hospital stay and confirmed the record did not reflect this outcome. Licensed nurse/operator A failed to ensure this resident's record included documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, actions taken and results of the actions regarding infections, transfers to hospital and a non-return from the hospital.	S5251		