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 02/01/2018

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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 a resurvey with investigation of complaint #116765 of the above home plus facility on 1/22/18, 1/23/18, 1/24/18, 1/25/18, 1/29/18, 1/30/18, 1/31/18, and 2/1/18.	S 000		
S 130 SS=F	26-39-103 (g) Resident Right Finance Management (g) Management of financial affairs. The administrator or operator shall ensure that each resident is afforded the right to manage personal financial affairs and is not required to deposit personal funds with the adult care home. This STANDARD is not met as evidenced by: KAR 26-39-103(g) The facility reported a census of 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on record review and interview for 4 (#120, #130, #140, and #150) of 5 residents sampled, operator/certified medication aide (CMA) B failed to ensure each resident was afforded the right to manage personal financial affairs and not provided option to deposit personal funds with the facility. Findings included: - Record review for residents #120, #130, #140, and #150 revealed the following: Resident #120 admitted on 12/16/16 with diagnoses of dementia, atrial fibrillation, and history of stroke.	S 130		

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

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S 130	Continued From page 1 Resident #130 admitted on 12/1/17 with diagnoses of hypertension, dementia, heart failure, and chronic obstructive pulmonary disease. Resident #140 admitted on 11/1/17 with diagnoses of history of stroke, type 2 diabetes mellitus, atrial fibrillation, and hypertension. Resident #150 admitted on 2/17/17 with diagnoses of paraplegia, hypertension, schizophrenia, and epilepsy. Each resident's record contained written resident rights provided to the resident at admission. The resident rights included a statement of "If the resident deposits funds with the home, it must manage and account for funds properly, including a quarterly written account of transactions on the account and the balance. If more than $50 is deposited with the home, the home must place the funds in an interest-bearing account in a Kansas financial institution." During an interview at 9:45 a.m. on 1/24/18, operator/CMA B confirmed residents had an option to deposit personal funds with facility but facility was not currently managing money for any resident. Operator/CMA B failed to ensure each resident was afforded the right to manage personal financial affairs and not provided option to deposit personal funds with the facility.	S 130		
S 230 SS=F	26-39-102 (b) (c) Admission Advanced Directives Resident Rights	S 230		

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S 230	Continued From page 2 b) At the time of admission, adult care home staff shall inform the resident or the resident ' s legal representative, in writing, of the state statutes related to advance medical directives. (1) If a resident has an advance medical directive currently in effect, the facility shall keep a copy on file in the resident ' s clinical record. (2) The administrator or operator, or the designee, shall ensure the development and implementation of policies and procedures related to advance medical directives. (c) The administrator or operator, or the designee, shall provide a copy of resident rights, the adult care home's policies and procedures for advance medical directives, and the adult care home's grievance policy to each resident or the resident's legal representative before the prospective resident signs any admission agreement. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(b)(c) The facility reported a census of 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on record review and interview for 4 (#120, #130, #140, and #150) of 5 residents sampled, operator/certified medication aide (CMA) B failed to ensure each resident was informed in writing of the state statutes related to advance medical directives and failed to provide a copy of the facility's policies and procedures for advance medical directives at the time of admission. Findings included:	S 230		

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S 230	Continued From page 3 - Record review for residents #120, #130, #140, and #150 revealed the following: Resident #120 admitted on 12/16/16 with diagnoses of dementia, atrial fibrillation, and history of stroke. Negotiated service agreement dated 12/14/17 documented "Code status: Full." Resident's record lacked documentation as evidence resident received in writing the state statutes related to advance medical directives and a copy of the facility's policies and procedures for advance medical directives at the time of admission. Resident #130 admitted on 12/1/17 with diagnoses of hypertension, dementia, heart failure, and chronic obstructive pulmonary disease. The record contained a "Do not resuscitate" (DNR) form signed by the resident prior to admission to the facility. Negotiated service agreement dated 12/1/17 documented "Code status: DNR." Resident's record lacked documentation as evidence resident received a copy of the facility's policies and procedures for advance medical directives at the time of admission. Resident #140 admitted on 11/1/17 with diagnoses of history of stroke, type 2 diabetes mellitus, atrial fibrillation, and hypertension. Negotiated service agreement dated 11/1/17 documented "Code status: Full ." Resident's record lacked documentation as evidence resident received in writing the state statutes related to advance medical directives and a copy of the facility's policies and procedures for advance medical directives at the time of admission. Resident #150 admitted on 2/17/17 with	S 230		

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S 230	Continued From page 4 diagnoses of paraplegia, hypertension, schizophrenia, and epilepsy. Negotiated service agreement dated 2/17/17 did not specify a code status. Medical care provider visit note dated 11/30/17 documented "Full code." Resident's record lacked documentation as evidence resident received in writing the state statutes related to advance medical directives and a copy of the facility's policies and procedures for advance medical directives at the time of admission. During an interview at 10:48 a.m. on 1/24/18, operator/CMA B stated he/she did not give any information in writing to residents at the time of admission regarding advance medical directives. Operator/CMA B stated he/she thought the medical care provider talked to residents about advance medical directives. Operator/CMA B went through an admission packet and stated there was no information on advance medical directives. At 11:38 a.m. on 1/24/18, owner/licensed nurse D stated if there was not written information regarding advance medical directives in the admission packet then nothing was provided in writing to the resident. Operator/CMA B failed to ensure each resident (#120, #130, #140, and #150) was informed in writing of the state statutes related to advance medical directives and failed to provide a copy of the facility's policies and procedures for advance medical directives at the time of admission.	S 230		
S5026 SS=J	26-42-101 (f) (1) Staff Treatment of residents ANE	S5026		

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S5026	Continued From page 5 (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(1)(A)(B) The facility reported a census of 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on record review, interview, and observation for 1 (#130) of 5 residents sampled, operator/certified medication aide (CMA) B failed to ensure no resident was subjected to neglect when interventions were not implemented to address the cognitively impaired resident's risk for elopement. The resident left the facility sometime between 12:30 a.m. and 2:30 a.m. through his/her bedroom window. This failure, placed resident #130 in jeopardy for harm, injury or death. Based on record review, observation, and interview for 1 (#110) of 5 residents sampled, operator/CMA failed to ensure no resident was subjected to abuse when staff members were instructed to toilet resident every 2 hours and not toilet when resident requested and if resident slid self out of wheelchair to floor to make resident comfortable on floor and wait 30 minutes to get resident up from floor.	S5026		

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S5026	Continued From page 6 Findings included: - Record review for resident #130 revealed an admission date of 12/1/17 with diagnoses of dementia, heart failure, hypertension, chronic obstructive pulmonary disease, and history of hip fracture. Functional capacity screen dated 12/1/17 indicated resident was independent with transferring, required physical assistance with walking, used a cane as an assistive device, and experienced impaired decision making. Negotiated service agreement/health care service plan (NSA/HCSP) dated 12/1/17 documented ambulation independent with cane and assist as needed and impaired decision making interventions of supervise, cue, reminders, choices not overwhelming, redirect to alternative options, educate, and assist as needed. Licensed nurse H documented on resident's admission on 12/1/17 that resident was alert, forgetful, easily distracted, confused, judgement impaired, short term memory and long term memory impairment, and oriented to person, place, situation. Record contained documentation by a medical care provider of a visit to resident in resident's home dated 11/2/17 with a facility staff member present. Medical care provider documented resident with disorganized thoughts, impaired abstract thinking, impaired problem-solving, impulsive, and impaired judgment. Record contained documentation by licensed nurse H dated 12/6/17 that he/she was notified at 9:20 a.m. by (operator/CMA B) that resident had	S5026		

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S5026	Continued From page 7	S5026		

signed self out of facility against staff advice. Resident stated he/she would return to facility around 6:00 p.m. after retrieving stolen money from another person. Operator/CMA B gave resident a facility business card. At 5:30 p.m. this nurse notified that resident was returned to facility and would be assessed by (owner/licensed nurse D).

Owner/licensed nurse D documented in the resident's record on 12/6/17 that (licensed nurse H) notified him/her at 9:30 a.m. that resident left facility. Owner/licensed nurse D advised operator/CMA B to contact adult protective services and resident's case manager. Owner/licensed nurse documented that resident was "legally competent and while (resident's) decision making may not be the best, we do not have the right to hold (resident) against (resident's) will, however upon (resident's) return we will need to make a plan with adult protective services and resident to eliminate future occurrences." Owner/licensed nurse D documented operator/CMA picked resident up and returned resident to facility at 5:00 p.m. Owner/licensed nurse D documented an assessment of resident at 5:30 p.m. with resident stable but tired and irritated that no one at hospital would listen to him/her.

Information submitted to the department by operator/CMA B regarding the incident documented the facility received a call 12/6/17 between 2:30 p.m. and 3 p.m. from EMS (emergency medical services) that resident #130 stopped them outside of a local hospital for a ride to a city in another state and the EMS staff took him inside the hospital. Resident #130 was not seen by any hospital staff except a social worker

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S5026	Continued From page 8 who called the facility to come pick (him/her) up. Operator/CMA B also stated he/she was working with adult protective services to get a legal guardian for Resident #130. Review of wunderground.com documented temperatures of 42 to 48 degrees Fahrenheit between 9 a.m. and 3 p.m. on 12/6/17. The local hospital was located approximately 2.5 miles from the facility on a 4 lane street with multiple business entrances. Record contained a managed risk agreement signed by resident, operator/CMA B, and owner/licensed nurse D on 12/7/17 that documented resident would not leave facility unassisted and unaccompanied by a staff member, family member, volunteer, personal friends, or acquaintances. The agreement documented that if resident decided to leave the facility unassisted resident would be given a 7 day eviction notice to find alternative living arrangements. The NSA/HCSP lacked documentation of interventions to address wandering or elopement. At 11:50 a.m. on 1/22/18, resident approached surveyor and stated he/she sometimes "slips out and goes to the bus station." Observed during time in the facility on 1/22/18 that resident wandered about facility and into backyard. At 12:00 p.m. on 1/23/18, surveyor went to the backyard and observed a wooden privacy fence around the yard with a gate located in the northwest corner of yard. Gate was held open with a cement block.	S5026		

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S5026	Continued From page 9 At 4:20 p.m. on 1/23/18, observed resident #130 unaccompanied in the backyard sweeping the deck. Surveyor asked operator/CMA if gate was open. Operator/CMA went to the backyard, moved the cement block, closed gate and secured with a sliding latch. Operator/CMA confirmed the gate could not be locked and resident #130 would be able to open the gate. Operator/CMA went back into house. Resident #130 walked over to the gate and touched the latch and stated to surveyor "They will not let me out of here to go get my money." Walked back into house with resident who stated he/she wanted to get out of here to go home. Resident could not state where home was but knew that he/she wanted to go to Kansas. Resident pointed west then north when describing direction he/she would go to get home. During an interview at 12:08 p.m. on 1/24/18, owner/licensed nurse D stated resident was at risk for elopement and no interventions had been implemented to address this risk. Informed owner/licensed nurse resident goes into backyard unaccompanied and that gate had been propped open but even if was closed resident #130 would be able to open gate. Surveyor noted resident's room is located on street side of facility but owner/licensed nurse D and operator/CMA stated resident would not go out through the window. At 4:20 p.m. on 1/25/18, owner/licensed nurse provided interventions of staff to observe resident when he/she was in the backyard, implementation of a smoking schedule for resident, and fence gate to be locked at all times with lock that was installed 1/25/18. Interventions were to be reviewed with staff at a 6:00 p.m. meeting on 1/25/18.	S5026		

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S5026	Continued From page 10 At 12:55 p.m. on 1/29/18, owner/licensed nurse D called to report that resident was returned to the facility at 2:30 a.m. on 1/28/18 by a police officer. Resident had left facility through his/her bedroom window. Staff member (certified staff F) told owner/licensed nurse D that at 12:30 a.m. on 1/28/18 resident was walking in hallway with a bag stating that he/she needed to go get his/her money. Staff member told resident someone would take resident to get money in the morning and redirected resident to bed. Owner/licensed nurse D stated resident was then taken to hospital by the officers because he/she was threatening to hurt self or other with a knife if he/she had to stay at the facility. Resident #130 was admitted to the hospital. Review of wunderground.com documented the temperature between midnight and 3 a.m. on 12/28/17 at 30 degrees Farhenheit. Phone interview at 2:04 p.m. on 1/30/18, owner/licensed nurse D stated he/she did not instruct staff on interventions to ensure resident's safety at all times other than when resident was in the backyard. Owner/licensed nurse D stated staff did not notify him/her of resident wanting to leave facility on 1/26/18 or 1/27/18 until he/she was notified of resident leaving facility 1/28/18. Phone interview at 3:12 p.m. on 1/30/18, operator/CMA B stated he/she reviewed with staff in meeting 1/25/18 the interventions for resident when in the backyard unaccompanied. Operator/CMA B stated "No." when asked if any other actions taken to address resident's risk for elopement. Operator/CMA B stated "No." when asked if resident showed increased behaviors and agitation on the days prior to the elopement on 1/28/18.	S5026		

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S5026	Continued From page 11 Operator/CMA B failed to ensure no resident was subjected to neglect when interventions were not implemented to address cognitively impaired resident #130's risk for elopement. - Record review for resident #110 revealed an admission date of 1/23/15 and diagnoses of history of stroke with left side affected, type 2 diabetes mellitus, hypertension, anxiety, and chronic schizoaffective disorder. Functional capacity screen dated 7/26/17 indicated resident was unable to toilet, transfer, or mobilize self; was frequently incontinent of urine; experienced impaired decision making; and required a mechanical lift to transfer and wheelchair for mobility. Negotiated service agreement/health care service plan (NSA/HCSP) dated 12/14/17 completed by licensed nurse H documented resident required a two-person transfer with sit-to-stand lift. NSA/HCSP documented staff to toilet resident every 2 hours and "Will be reminded of 2 hour agreement if (resident) request restroom attention sooner." Licensed nurse H documented that resident exhibited attention-seeking behavior and would constantly yell. Licensed nurse H documented "Resident slides self to floor at times with behaviors. Resident to be made comfortable and assisted up after 30 minutes." At 9:19 a.m. on 1/22/18, surveyor observed resident #110 sitting in a wheelchair at dining room table. Resident occasionally called out to staff with different requests including need to toilet. At 10:23 a.m. surveyor noted foul odor in area where resident sat in wheelchair. Certified staff C informed operator/CMA B that he/she was	S5026		

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S5026	Continued From page 12	S5026		

taking resident to bathroom because resident had "already gone."

Record contained documentation by a licensed nurse that resident experienced falls from chair as follows:

1/29/17 that resident leaned too far forward in wheelchair and fell on face on 1/25/17. Resident received bruising to bridge of nose and under right eye at time of fall.

4/24/17 that resident was sitting on shower chair, staff went to doorway to call for assistance to transfer resident to wheelchair, and resident fell forward out of shower chair. Licensed nurse documented resident was not injured.

9/6/17 at 7:05 p.m. resident fell out of wheelchair when trying to move a table closer to him/her. Resident received an abrasion above left eye and a scratch on left anterior thigh.

These entries did not include information if resident was gotten up from floor immediately or made comfortable and then assisted up after 30 minutes.

During an interview at 12:43 p.m. on 1/24/18, owner/licensed nurse D stated he/she thought licensed nurse H added to NSA/HCSP to leave resident on floor for 30 minutes after sliding self out of chair because resident refused to get up after sliding out of chair. Owner/licensed nurse D stated staff toileted resident every 2 hours because when resident would ask more frequently and was toileted resident would then say he/she did not need to go to bathroom.

Operator/CMA failed to ensure resident #110 was

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S5026	Continued From page 13 not subjected to abuse when staff members were instructed to toilet resident every 2 hours and not toilet when resident requested and if resident slid self out of wheelchair to floor to make resident comfortable on floor and wait 30 minutes to get resident up from floor.	S5026		
S5065 SS=E	26-42-200 (a) Resident Criteria (a) The administrator or operator of each home plus shall ensure the development and implementation of written admission, transfer, and discharge policies that protect the rights of each resident, pursuant to K.A.R. 26-39-102. In addition, the administrator or operator shall ensure that any resident who has one or more of the following conditions is not admitted or retained unless the negotiated service agreement includes services sufficient to meet the needs of the resident: (1) Incontinence, if the resident cannot or will not participate in management of the problem; (2) immobility, if the resident is totally dependent on another person ' s assistance to exit the building; (3) any ongoing condition requiring two or more persons to physically assist the resident; (4) any ongoing, skilled nursing intervention needed 24 hours a day; or (5) any behavioral symptom that exceeds manageability. This REQUIREMENT is not met as evidenced by: KAR 26-42-200(a)(2)(3)(5) The facility reported a census of 8 residents. The sample included 5 residents and 2 closed records	S5065		

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reviewed. Based on record review, observation, and interview for 4 (#150, #110, #120, and #140) of 5 residents sampled, operator/certified medication aide (CMA) B failed to ensure that residents with immobility who were totally dependent on another person's assistance to exit the building and any ongoing condition requiring two persons to transfer the resident were not admitted or retained unless the negotiated service agreement included services sufficient to meet the needs of the resident. Based on record review, observation, and interview for 1 (#150) of 5 residents sampled, operator/CMA B failed to ensure the resident with behavioral symptoms that exceeded manageability was not retained unless the negotiated service agreement included services sufficient to meet the needs of the resident.

Findings included:

- Record review for resident #150 revealed an admission date of 2/17/17 with diagnoses of paraplegia, hypertension, schizophrenia, and epilepsy.

Functional capacity screen dated 2/17/17 indicated resident was unable to perform bathing, dressing, toileting, transferring, mobility, and management of medications and medical treatments; required a wheelchair for mobility, experienced impaired short term memory, long term memory, memory recall, and decision making; and was incontinent of urine.

Negotiated service agreement (NSA) dated 2/17/17 documented resident to receive total assistance with bathing, dressing, two-person transfer, and mobility in wheelchair; incontinent of bowel and bladder; staff administration of

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medication; housekeeping; laundry; and meal preparation.

During tour of the facility at 9:19 a.m. on 1/22/18, operator/CMA B knocked on the resident's door, opened door and introduced surveyor to resident. Resident was in bed watching television. Surveyor noted a strong foul odor in the room while standing just outside the door. Operator/CMA B stated resident had a foul body odor and he/she noticed resident's trash was full.

During an interview at 4:30 p.m. on 1/23/18, operator/CMA B stated resident exhibited behaviors directed at staff. Operator/CMA explained that when he/she takes medications to resident that another certified staff accompanies him/her because resident has thrown urine and feces at him/her. Operator/CMA B stated resident's care needs exceeded what they could provide.

Interview with resident #150 in his/her room at 4:45 p.m. on 1/23/18 and noted room clean and without odor. Resident stated that he/she had not had a shower for 3 to 4 weeks due to staff not wanting to put him/her on shower chair. Surveyor asked resident if staff providing incontinence care and management and resident stated he/she pulls brief out from under self and cleans self the best that he/she can. Resident pointed to trash can and stated he/she just removed a wet brief. Resident confirmed he/she had a history of skin breakdown and reported some stinging felt on buttocks at present. Surveyor asked resident if he/she allowed staff to reposition him/her to prevent skin breakdown. Resident stated he/she could shift weight when needed.

During an interview at 10:30 a.m. on 1/24/18,

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operator/certified staff B stated resident allowed only certified staff F to bathe resident and resident's last shower was likely 1/12/18. Operator/CMA B stated resident would require total assistance to exit the facility and required a two-person transfer.

During an interview at 11:38 a.m. on 1/24/18, owner/licensed nurse D stated resident did have behaviors that were difficult to manage.

NSA lacked a description of services to ensure resident would receive total assistance to exit the facility and interventions related to socially inappropriate behaviors.

Comparison of time clock records and payroll details report from 11/13/17 through 1/21/18 failed to demonstrate 2 staff on duty at all times.

Operator/CMA B failed to ensure resident #150 who was totally dependent on another person's assistance to exit the building, required two-person transfer assistance, and exhibited behavioral symptoms that exceeded manageability was not retained unless the negotiated service agreement included services sufficient to meet the needs of the resident.

- Record review for resident #110 revealed an admission date of 1/23/15 with diagnoses of history of stroke with left side affected, chronic schizoaffective disorder, type 2 diabetes mellitus, anxiety, and hypertension.

Functional capacity screen dated 7/26/17 indicated resident was unable to perform transferring and mobility, experienced impaired decision making, and required a wheelchair for mobility and a mechanical lift for transferring.

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S5065	Continued From page 17 Negotiated service agreement dated 12/4/17 documented total assistance to transfer with 2 staff members using a sit-to-stand lift. The negotiated service agreement lacked a description of services to ensure resident would receive total assistance to exit building. Comparison of time clock records and payroll details report from 11/13/17 through 1/21/18 failed to demonstrate 2 staff on duty at all times. At 1:00 p.m. on 1/22/18, surveyor observed certified staff C and certified staff E transfer resident #110 from wheelchair to bed using a sit-to-stand lift. Surveyor observed resident unable to bear weight on left leg. During an interview at 12:43 p.m. on 1/24/18, owner/licensed nurse D stated resident would need total assistance of a staff person to exit the facility and required 2 staff to transfer. Operator/CMA B failed to ensure resident #110 who experienced immobility and was totally dependent on another person's assistance to exit the building and required two-person transfer assistance was not retained unless the negotiated service agreement included services sufficient to meet the needs of the resident. - Record review for resident #120 revealed an admission date of 12/16/16 with diagnoses of dementia, atrial fibrillation, and stroke. Functional capacity screen dated 12/16/16 indicated resident required physical assistance with transferring, was independent with mobility, utilized a walker for mobility, and experienced impaired long term memory, memory recall, and	S5065		

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decision making. Record lacked a more recent functional capacity screen.

Negotiated service agreement dated 12/14/17 documented resident to receive two-person transfer assistance, use sit-to-stand lift, and wheelchair for mobility.

At 12:29 p.m. on 1/24/18, owner/licensed nurse D stated resident currently in hospital due to possible stroke. Owner/licensed nurse D stated resident required total assistance of staff to exit building and two-person transfer assistance.

Negotiated service agreement dated 12/14/17 lacked a description of services to ensure resident would receive total assistance to exit building.

Comparison of time clock records and payroll details report from 11/13/17 through 1/21/18 failed to demonstrate 2 staff on duty at all times.

Operator/CMA B failed to ensure resident #120 who was totally dependent on another person's assistance to exit the building and required two-person transfer assistance was not retained unless the negotiated service agreement included services sufficient to meet the needs of the resident.

- Record review for resident #140 revealed an admission date of 11/1/17 with diagnoses of stroke with left side hemiplegia, type 2 diabetes mellitus, atrial fibrillation, and hypertension.

Functional capacity screen dated 11/1/17 indicated resident was unable to perform transferring and mobility, required a Hoyer lift and two-person transfer assistance, a wheelchair for

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S5065	Continued From page 19 mobility, and experienced impaired long term memory and memory recall. Negotiated service agreement dated 11/1/17 documented total assistance of 2 staff to transfer, may use Hoyer lift as needed, and wheelchair for mobility. During an interview at 12:40 p.m. on 1/24/18, operator/CMA B stated resident would require total assistance of staff to exit the facility. Negotiated service agreement dated 11/1/17 lacked a description of this service. During an interview at 1:43 p.m. on 1/24/18, certified staff C stated and confirmed resident required a two-person transfer. Comparison of time clock records and payroll details report from 11/13/17 through 1/21/18 failed to demonstrate 2 staff on duty at all times. Operator/CMA B failed to ensure resident #140 who was totally dependent on another person's assistance to exit the building and required two-person transfer assistance was not retained unless the negotiated service agreement included services sufficient to meet the needs of the resident.	S5065		
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	S5085		

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S5085	Continued From page 20 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)(1) The facility reported a census of 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on record review and interview for 1(#120) of 5 residents sampled, operator/certified medication aide (CMA) B failed to ensure a licensed nurse conducted a screening to determine the resident's functional capacity at least once every 365 days. Findings included: - Record review for resident #120 revealed an admission date of 12/16/16 with diagnoses of dementia, atrial fibrillation, and history of stroke. Record contained an admission functional capacity screen dated 12/16/16. The record lacked a subsequent functional capacity screen. During an interview at 3:38 p.m. on 1/22/18, operator/CMA B stated no other functional capacity screen for the resident. Operator/CMA B failed to ensure a licensed nurse conducted a screening to determine resident #120's functional capacity at least once every 365 days.	S5085		

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S5095	Continued From page 21	S5095		
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 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on record review and interview for 1 (#110) of 5 residents sampled, operator/certified medication aide (CMA) B failed to ensure the licensed nurse documented accurately on the resident's functional capacity screen that resident was at risk for falls. Findings included: - Record review for resident #110 revealed an admission date of 1/23/15 and diagnoses of type 2 diabetes mellitus, history of stroke with left side affected, anxiety, and chronic schizoaffective disorder. Record contained documentation by a licensed nurse on 1/29/17 that resident leaned too far forward in wheelchair and fell on face on 1/25/17. Resident received bruising to bridge of nose and under right eye at time of fall and bruising now resolved. Record contained documentation by a licensed	S5095		

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S5095	Continued From page 22 nurse on 4/24/17 that resident was sitting on shower chair, staff went to doorway to call for assistance to transfer resident to wheelchair, and resident fell forward out of shower chair. Licensed nurse documented resident was not injured. Functional capacity screen dated 7/26/17 indicated resident was unable to perform toileting, transferring, and mobility. The functional capacity screen did not indicate resident was unsteady and at risk for falls. Functional capacity screen manual documents instruction to person completing the screening to mark that resident is at risk for falls if "Resident has fallen within last 180 days and/or exhibits unsteadiness when arising from chair or when walking." During an interview at 12:43 p.m. on 1/24/18, owner/licensed nurse D stated the licensed nurse conducting the functional screening should have marked resident at risk for falls. Operator/CMA B failed to ensure the licensed nurse documented accurately on the resident's functional capacity screen that resident was at risk for falls.	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	S5105		

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S5105	Continued From page 23 agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the 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 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on record review and interview for 1 (#150) of 5 residents sampled, operator/certified medication aide (CMA) B failed to ensure the resident's negotiated service agreement (NSA) included the identity of an outside resource, the service provided, and the party responsible for payment to the outside resource. Based on record review and interview for 1 (#140) of 5 residents sampled, operator/CMA B failed to ensure resident's NSA included the service provided and the party responsible for payment to the outside resource. Based on record review and interview for 2 (#110 and #130) of 5 residents sampled operator/CMA B failed to ensure each resident's NSA included the service provided by an outside resource. Findings included: - Record review for resident #150 revealed an admission date of 2/17/17 with diagnoses of paraplegia, hypertension, schizophrenia, and	S5105		

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epilepsy.

Functional capacity screen dated 2/17/17 indicated resident was unable to perform bathing, dressing, toileting, transferring, mobility, and management of medications and medical treatments and was incontinent of urine.

Record contained a medical care provider's visit note dated 3/2/17 that documented plan for home health to visit for wound care.
A licensed nurse documented in the resident's record on 3/7/17 that home health began services of occupational therapy, physical therapy, and skilled nursing.

NSA dated 2/17/17 lacked the name of the home health provider, a description of services provided, and the party responsible to pay for the services.

At 2:03 p.m. on 1/22/18, operator/CMA B provided home health skilled nursing visit notes dated 3/4/17, 3/13/17, 3/17/17, and 3/20/17. Operator/CMA B stated resident no longer received home health services and did not know when services were discontinued.

Operator/CMA B failed to ensure resident #150's NSA included the identity of an outside resource, the service provided, and the party responsible for payment to the outside resource.

- Record review for resident #140 revealed an admission date of 11/1/17 with diagnoses of stroke with left side hemiplegia, type 2 diabetes mellitus, atrial fibrillation, and hypertension.

Functional capacity screen dated 11/1/17 indicated resident was unable to perform

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transferring, mobility, toileting, and management of medications and medical treatments, and required physical assistance with bathing and dressing.

Record contained a medical care provider's order dated 11/3/17 for resident to receive physical therapy, occupational therapy, and speech therapy for generalized weakness and dysphagia (difficulty swallowing).

Resident's NSA dated 11/1/17 documented the name of an outside provider but lacked a description of services and party responsible for payment of the services.

During an interview at 12:40 p.m. on 1/24/18, owner/licensed nurse D confirmed the resident's NSA lacked a description of services and party responsible for payment of the services.

Operator/CMA B failed to ensure resident #140's NSA included the service provided by an outside resource and the party responsible for payment to the outside resource.

- Record review for resident #110 revealed an admission date of 1/23/15 with diagnoses of history of stroke with left side affected, chronic schizoaffective disorder, type 2 diabetes mellitus, and hypertension.

Functional capacity screen dated 7/26/17 indicated resident was unable to perform toileting, transferring, mobility, and management of medications and medical treatments.

NSA dated 12/4/17 documented the name of an outside provider and the party responsible for payment of the services but lacked a description

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of services provided.

During an interview at 4:30 p.m. on 1/22/18, operator/CMA B stated a home health nurse administered fluphenazine (recorded on resident's medication administration record to treat bipolar disorder) injections.

Operator/CMA B failed to ensure resident #110's NSA included a description of the service provided by an outside resource.

- Record review for resident #130 revealed an admission date of 12/1/17 with diagnoses of dementia, heart failure, hypertension, chronic obstructive pulmonary disease, and history of hip fracture.

Functional capacity screen dated 12/1/17 indicated resident required physical assistance with walking and was at risk for falls

NSA dated 12/1/17 documented service of assistance with walking as needed and remind resident to use cane, take slow steps, and ask for assistance as needed. NSA documented the name of an outside provider and the party responsible for payment to the outside provider but lacked a description of services to be provided.

Record contained a medical care provider's order for physical therapy and occupational therapy for generalized weakness.

During an interview at 12:08 p.m. on 1/24/18, operator/CMA B stated resident received physical therapy and occupational therapy from an outside provider but resident's NSA did not specify these services.

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S5105	Continued From page 27 Operator/CMA B failed to ensure resident #130's NSA included a description of the service provided by an outside resource.	S5105		
S5130 SS=E	26-42-202 (j) NSA Outside Resources (j) If a resident's negotiated service agreement includes the use of outside resources, the designated staff shall perform the following: (1) Provide the resident, the resident's legal representative, the case manager, and, if agreed to by the resident or resident ' s legal representative, the resident ' s family, with a list of providers available to provide needed services; (2) assist the resident, if requested, in contacting outside resources for services; and (3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(j)(3) The facility reported a census of 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on record review and interview for 4 (#110, #130, #140, and #150) of 5 residents sampled, operator/certified medication aide (CMA) B failed to monitor the services provided by an outside resource. Findings included: - Record review for resident #110 revealed an admission date of 1/23/15 with diagnoses of history of stroke with left side affected, chronic	S5130		

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S5130	Continued From page 28 schizoaffective disorder, type 2 diabetes mellitus, and hypertension. Functional capacity screen dated 7/26/17 resident was unable to perform management of medications. During an interview at 4:30 p.m. on 1/22/18, operator/CMA B stated a home health nurse administered fluphenazine (recorded on resident's medication administration record to treat bipolar disorder) injections. On 1/23/18, surveyor reviewed resident #110's 1/1/18 through 1/31/18 medication administration record (MAR). The MAR documented resident to receive fluphenazine decanoate 75 milligrams intramuscularly every other week. The MAR contained initials to indicate resident received the injection on 1/4/18. The MAR did not indicate resident received the injection 2 weeks after the injection on 1/4/18. At 12:43 p.m. on 1/24/18, owner/licensed nurse D stated do not monitor outside provider if visits made as scheduled. Operator/CMA B failed to monitor the services provided by an outside resource to resident #110. - Record review for resident #130 revealed an admission date of 12/1/17 with diagnoses of dementia, heart failure, hypertension, chronic obstructive pulmonary disease, and history of hip fracture. Functional capacity screen dated 12/1/17 indicated resident required physical assistance with walking and was at risk for falls	S5130		

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S5130	Continued From page 29 NSA dated 12/1/17 documented service of assistance with walking as needed and remind resident to use cane, take slow steps, and ask for assistance as needed. NSA documented the name of an outside provider and the party responsible for payment to the outside provider but lacked a description of services to be provided. Record contained a medical care provider's order for physical therapy and occupational therapy for generalized weakness. During an interview at 12:08 p.m. on 1/24/18, operator/CMA B stated resident received physical therapy and occupational therapy from an outside provider. Operator/CMA B stated he/she did not monitor services provided to the resident by an outside resource. Operator/CMA B failed to monitor the services provided by an outside resource to resident #130. - Record review for resident #140 revealed an admission date of 11/1/17 with diagnoses of stroke with left side hemiplegia, type 2 diabetes mellitus, atrial fibrillation, and hypertension. Functional capacity screen dated 11/1/17 indicated resident was unable to perform transferring, mobility, toileting, and management of medications and medical treatments, and required physical assistance with bathing and dressing. Record contained a medical care provider's order dated 11/3/17 for resident to receive physical therapy, occupational therapy, and speech therapy for generalized weakness and dysphagia (difficulty swallowing).	S5130		

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S5130	Continued From page 30 Record contained documentation by a licensed nurse on 11/15/17 that resident continued with physical therapy, occupational therapy, and speech therapy. On 11/24/17, a licensed nurse documented resident completed physical therapy on 11/20/17. Resident's record lacked documentation if resident continued with or completed occupational therapy and speech therapy. Operator/CMA B failed to monitor the services provided by an outside resource to resident #140. - Record review for resident #150 revealed an admission date of 2/17/17 with diagnoses of paraplegia, hypertension, schizophrenia, and epilepsy. Functional capacity screen dated 2/17/17 indicated resident was unable to perform management of medications and medical treatments. Record contained a medical care provider's visit note dated 3/2/17 that documented plan for home health to visit for wound care. A facility licensed nurse documented in the resident's record on 3/7/17 that home health began services of occupational therapy, physical therapy, and skilled nursing. The licensed nurse documented resident had a wound in perineal area measuring approximately 1 centimeter by 2 centimeters and 0.5 centimeter deep. Resident's record lacked further documentation of wound care and assessments or documentation of services provided by skilled nursing, physical therapy, and occupational therapy. Negotiated service agreement dated 2/17/17	S5130		

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S5130	Continued From page 31 lacked the name of the home health provider and a description of services provided, and the party responsible to pay for the services. At 2:03 p.m. on 1/22/18, operator/CMA B provided home health skilled nursing visit notes dated 3/4/17, 3/13/17, 3/17/17, and 3/20/17. Operator/CMA B stated resident no longer received home health services and did not know when services were discontinued. Operator/CMA B failed to monitor the services provided by an outside resource to resident #150.	S5130		
S5155 SS=E	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 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on record review, observation, and interview for 4 (#130, #150, #140, and #110) of 5 residents sampled, operator/certified medication aide (CMA) B failed to ensure a licensed nurse provided or coordinated the	S5155		

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provision of necessary health care services that met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement.

Findings included:

- Record review for resident #130 revealed an admission date of 12/1/17 with diagnoses of dementia, heart failure, hypertension, chronic obstructive pulmonary disease, and history of hip fracture.

Functional capacity screen dated 12/1/17 indicated resident was independent with transferring, required physical assistance with walking, used a cane as an assistive device, and experienced impaired decision making.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 12/1/17 documented ambulation independent with cane and assist as needed and impaired decision making interventions of supervise, cue, reminders, choices not overwhelming, redirect to alternative options, educate, and assist as needed.

Licensed nurse H documented on resident's admission on 12/1/17 that resident was alert, forgetful, easily distracted, confused, judgement impaired, short term memory and long term memory impairment, and oriented to person, place, situation.

Record contained documentation by a medical care provider of a visit to resident in resident's home dated 11/2/17 with a facility staff member present. Medical care provider documented resident with disorganized thoughts, impaired abstract thinking, impaired problem-solving,

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impulsive, and impaired judgment.

Record contained documentation by licensed nurse H dated 12/6/17 that he/she was notified at 9:20 a.m. by (operator/CMA B) that resident had signed self out of facility against staff advice. Resident stated he/she would return to facility around 6:00 p.m. after retrieving stolen money from another person. Operator/CMA B gave resident a facility business card. At 5:30 p.m. this nurse notified that resident was returned to facility and would be assessed by (owner/licensed nurse D).

Owner/licensed nurse D documented in the resident's record on 12/6/17 that (licensed nurse H) notified him/her at 9:30 a.m. that resident left facility. Owner/licensed nurse D advised operator/CMA B to contact adult protective services and resident's case manager. Owner/licensed nurse documented that resident was "legally competent and while (resident's) decision making may not be the best, we do not have the right to hold (resident) against (resident's) will, however upon (resident's) return we will need to make a plan with adult protective services and resident to eliminate future occurrences." Owner/licensed nurse D documented operator/CMA picked resident up and returned resident to facility at 5:00 p.m. Owner/licensed nurse D documented an assessment of resident at 5:30 p.m. with resident stable but tired and irritated that no one at hospital would listen to him/her.

Information submitted to the department by operator/CMA B regarding the incident documented the facility received a call 12/6/17 between 2:30 p.m. and 3 p.m. from EMS (emergency medical services) that resident #130

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stopped them outside of a local hospital for a ride to a city in another state and the EMS staff took (him/her) inside the hospital. Resident #130 was not seen by any hospital staff except a social worker who called the facility to come pick him up. Operator/CMA B also stated he/she was working with adult protective services to get a legal guardian for Resident #130.

Review of wunderground.com documented temperatures of 42 to 48 degrees Fahrenheit between 9 a.m. and 3 p.m. on 12/6/17. The local hospital was located approximately 2.5 miles from the facility on a 4 lane street with multiple business entrances.

Record contained a managed risk agreement signed by resident, operator/CMA B, and owner/licensed nurse D on 12/7/17 that documented resident would not leave facility unassisted and unaccompanied by a staff member, family member, volunteer, personal friends, or acquaintances. The agreement documented that if resident decided to leave the facility unassisted resident would be given a 7 day eviction notice to find alternative living arrangements.

The NSA/HCSP lacked documentation of interventions to address wandering or elopement.

At 11:50 a.m. on 1/22/18, resident approached surveyor and stated he/she sometimes "slips out and goes to the bus station." Observed during time in the facility on 1/22/18 that resident wandered about facility and into backyard.

At 12:00 p.m. on 1/23/18, surveyor went to the backyard and observed a wooden privacy fence around the yard with a gate located in the

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northwest corner of yard. Gate was held open with a cement block.

At 4:20 p.m. on 1/23/18, observed resident #130 unaccompanied in the backyard sweeping the deck. Surveyor asked operator/CMA B if gate was open. Operator/CMA B went to the backyard, moved the cement block, closed gate and secured with a sliding latch. Operator/CMA B confirmed the gate could not be locked and resident #130 would be able to open the gate. Operator/CMA B went back into house. Resident #130 walked over to the gate and touched the latch and stated to surveyor "They will not let me out of here to go get my money." Walked back into house with resident who stated he/she wanted to get out of here to go home. Resident could not state where home was but knew that he/she wanted to go to Kansas. Resident pointed west then north when describing direction he/she would go to get home.

During an interview at 12:08 p.m. on 1/24/18, owner/licensed nurse D stated resident was at risk for elopement and no interventions had been implemented to address this risk. Informed owner/licensed nurse resident goes into backyard unaccompanied and that gate had been propped open but even if was closed resident #130 would be able to open gate. Surveyor noted resident's room is located on street side of facility but owner/licensed nurse D and operator/CMA stated resident would not go out through the window.

At 4:20 p.m. on 1/25/18, owner/licensed nurse provided interventions of staff to observe resident when he/she was in the backyard, implementation of a smoking schedule for resident, and fence gate to be locked at all times with lock that was installed 1/25/18. Interventions

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were to be reviewed with staff at a 6:00 p.m. meeting on 1/25/18.

At 12:55 p.m. on 1/29/18, owner/licensed nurse D called to report that resident was returned to the facility at 2:30 a.m. on 1/28/18 by a police officer. Resident had left facility through his/her bedroom window. Staff member (certified staff F) told owner/licensed nurse D that at 12:30 a.m. on 1/28/18 resident was walking in hallway with a bag stating that he/she needed to go get his/her money. Staff member told resident someone would take resident to get money in the morning and redirected resident to bed. Owner/licensed nurse D stated resident was then taken to hospital by the officers because he/she was threatening to hurt self or other with a knife if he/she had to stay at the facility. Resident #130 was admitted to the hospital.

Review of wunderground.com documented the temperature between midnight and 3 a.m. on 12/28/17 at 30 degrees Fahrenheit.

Phone interview at 2:04 p.m. on 1/30/18, owner/licensed nurse D stated he/she did not instruct staff on interventions to ensure resident's safety at all times other than when resident was in the backyard.

Phone interview at 3:12 p.m. on 1/30/18, operator/CMA B stated he/she reviewed with staff in meeting 1/25/18 the interventions for resident when in the backyard unaccompanied. Operator/CMA B stated "No." when asked if any other actions taken to address resident's risk for elopement.

Operator/CMA B failed to ensure a licensed nurse provided or coordinated the provision of

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necessary health care services that met the needs of resident #130.

- Record review for resident #150 revealed an admission date of 2/17/17 with diagnoses of paraplegia, hypertension, schizophrenia, and epilepsy.

Functional capacity screen dated 2/17/17 indicated resident was unable to perform bathing, dressing, toileting, transferring, mobility, and management of medications and medical treatments; required a wheelchair for mobility, experienced impaired short term memory, long term memory, memory recall, and decision making; and was incontinent of urine.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 2/17/17 documented resident to receive total assistance with bathing, dressing, two-person transfer, and mobility in wheelchair; incontinent of bowel and bladder; staff administration of medication; housekeeping; laundry; and meal preparation.

Record contained documentation by licensed nurse H as follows:

3/7/17 home health to treat resident's wound in perineal area measuring 1 centimeter by 2 centimeter and 0.5 centimeter deep.

2/18/17 resident rolled out of bed.

4/4/17 resident slid out of bed and received a 10 centimeter superficial scratch to right upper arm.

4/12/17 that at approximately 5:10 p.m. resident fell when attempting to get out of wheelchair and crawl to bed.

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S5155	Continued From page 38 5/12/17 resident sent to emergency department 5/8/17 with tremor and report of feeling like having a seizure. Resident has been noncompliant with medications. Admitted to hospital to get Keppra (medication to prevent seizures) level up. 6/13/17 marked improvement in coccyx skin breakdown. 6/20/17 coccyx skin breakdown stable. Stage 1 (skin intact but discolored) 7/3/17 at 4:32 p.m. resident called for help and reported he/she had a seizure. Resident with confusion and altered level of confusion. Resident transported to emergency department and then back to facility. 7/31/17 unwitnessed seizure, sent to emergency department and returned to facility. 8/10/17 ulcer to coccyx healed. 9/11/17 sent to hospital emergency department by ambulance at resident's request after having seizure. Resident's NSA/HCSP lacked interventions for care of resident during and after resident experienced a seizure. NSA/HCSP lacked interventions to address resident's risk for falls and measures to promote wound healing and prevent skin breakdown. During tour of the facility at 9:19 a.m. on 1/22/18, operator/CMA B knocked on the resident's door, opened door and introduced surveyor to resident. Resident was in bed watching television.	S5155		

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S5155	Continued From page 39 Surveyor noted a strong foul odor in the room while standing just outside the door. Operator/CMA B stated resident had a foul body odor and he/she noticed resident's trash was full. During an interview at 4:30 p.m. on 1/23/18, operator/CMA B stated resident exhibited behaviors directed at staff. Operator/CMA explained that when he/she takes medications to resident that another certified staff accompanies him/her because resident has thrown urine and feces at him/her. Operator/CMA B stated resident's care needs exceeded what they could provide. Interview with resident #150 in his/her room at 4:45 p.m. on 1/23/18 and noted room clean and without odor. Resident stated that he/she had not had a shower for 3 to 4 weeks due to staff not wanting to put him/her on shower chair. Surveyor asked resident if staff providing incontinence care and management and resident stated he/she pulls brief out from under self and cleans self the best that he/she can. Resident pointed to trash can and stated he/she just removed a wet brief. Resident confirmed he/she had a history of skin breakdown and reported some stinging felt on buttocks at present. Surveyor asked resident if he/she allowed staff to reposition him/her to prevent skin breakdown. Resident stated he/she could shift weight when needed. During an interview at 10:30 a.m. on 1/24/18, operator/certified staff B stated resident allowed only certified staff F to bathe resident and resident's last shower was likely when certified staff F last worked on 1/12/18. Resident's NSA/HCSP lacked interventions to address resident's socially inappropriate	S5155		

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behaviors, interventions to ensure resident received proper incontinence management. NSA/HCSP documented resident to receive total assistance with bathing 2 times a week. Resident did not receive bathing assistance 2 times a week.

Operator/CMA B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #150 and were in accordance with the functional capacity screening and the negotiated service agreement.

- During tour of the facility at 9:19 a.m. 1/22/18, surveyor observed a 3/4 bedrail on resident #140's bed with other side of bed against the wall.

Record review for resident #140 revealed an admission date of 11/1/17 with diagnoses of stroke with left side hemiplegia, type 2 diabetes mellitus, atrial fibrillation, and hypertension.

Functional capacity screen dated 11/1/17 indicated resident was unable to perform transferring and mobility, required a Hoyer lift and two-person transfer assistance, a wheelchair for mobility, and experienced impaired long term memory and memory recall.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 11/1/17 documented total assistance of 2 staff to transfer, may use Hoyer lift as needed, and wheelchair for mobility.

NSA/HCSP lacked a description of resident's use of or need for a bedrail.

Record lacked an assessment of the safety of the bedrail and resident's ability to safely use the

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bedrail.

During an interview at 12:40 p.m. on 1/24/18, operator/CMA B stated resident used the bedrail when repositioning self in bed. Owner/licensed nurse D confirmed and stated the record lacked an assessment of the safety of the bedrail and resident's ability to safely use the bedrail. Operator/licensed nurse D also confirmed and stated the NSA/HCSP lacked a description of resident's use of bedrail.

Operator/CMA B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #140.

- Record review for resident #110 revealed an admission date of 1/23/15 and diagnoses of history of stroke with left side affected, type 2 diabetes mellitus, hypertension, anxiety, and chronic schizoaffective disorder.

Functional capacity screen dated 7/26/17 indicated resident was unable to toilet, transfer, or mobilize self; was frequently incontinent of urine; experienced impaired decision making; and required a mechanical lift to transfer and wheelchair for mobility.
The functional capacity screen did not identify resident at risk for falls.

Record contained documentation by a licensed nurse that resident experienced falls from chair as follows:

1/29/17 that resident leaned too far forward in wheelchair and fell on face on 1/25/17. Resident received bruising to bridge of nose and under right eye at time of fall.

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S5155	Continued From page 42 4/24/17 that resident was sitting on shower chair, staff went to doorway to call for assistance to transfer resident to wheelchair, and resident fell forward out of shower chair. Licensed nurse documented resident was not injured. 9/6/17 at 7:05 p.m. resident fell out of wheelchair when trying to move a table closer to him/her. Resident received an abrasion above left eye and a scratch on left anterior thigh. Negotiated service agreement/health care service plan (NSA/HCSP) dated 12/14/17 lacked a description of services to address resident's risk for falls. During an interview at 12:43 p.m. on 1/24/18, owner/licensed nurse D stated and confirmed the resident's NSA/HCSP lacked interventions to address resident's risk for falls. Operator/CMA B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #110.	S5155		
S5170 SS=E	26-42-204 (g) (h) Health Care Services (g) Skilled nursing care shall be provided in accordance with K.S.A. 39-923 and amendments thereto. (1) The health care service plan shall include the skilled nursing care to be provided and the name of the licensed nurse or agency responsible for providing each service. (2) The licensed nurse providing the skilled nursing care shall document the service and the outcome of the service in the resident ' s record.	S5170		

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S5170	Continued From page 43 (3) A medical care provider ' s order for skilled nursing care shall be documented in the resident ' s record in the home. A copy of the medical care provider ' s order from a home health agency or hospice may be used. (4) The administrator or operator shall ensure that a licensed nurse is available to meet each resident ' s unscheduled needs related to skilled nursing services. (h) A licensed nurse may provide wellness and health monitoring as specified in the resident ' s negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(g)(1)(2) The facility reported a census of 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on record review and interview for 2 (#110 and #150) of 5 residents sampled, operator/certified medication aide (CMA) B failed to ensure each resident's health care service plan included the skilled nursing care to be provided and the name of the licensed nurse or agency responsible for providing the service and failed to ensure the licensed nurse providing the skilled nursing care documented the service and the outcome of the service in the resident's record. Findings included: - Record review for resident #110 revealed an admission date of 1/23/15 with diagnoses of history of stroke with left side affected, chronic schizoaffective disorder, anxiety, type 2 diabetes mellitus, and hypertension. Functional capacity screen dated 7/26/17	S5170		

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indicated resident was unable to perform management of medications.

During an interview at 4:30 p.m. on 1/22/18, operator/CMA B stated a home health nurse administered fluphenazine (recorded on resident's medication administration record to treat bipolar disorder) injections.

Negotiated service agreement/health care service plan dated 12/14/17 documented the name of an outside provider but lacked documentation of a skilled nursing service provided.

On 1/23/18, surveyor reviewed resident #110's 1/1/18 through 1/31/18 medication administration record (MAR). The MAR documented resident to receive fluphenazine decanoate 75 milligrams intramuscularly every other week. The MAR contained initials to indicate resident received the injection on 1/4/18. The MAR did not indicate resident received the injection 2 weeks after the injection on 1/4/18. Resident's record lacked documentation by the nurse administering the medication.

At 12:43 p.m. on 1/24/18, owner/licensed nurse D stated the home health nurse also performed a nursing assessment of resident with each visit in addition to medication administration. Owner/licensed nurse D confirmed the home health nurse did not document resident assessments in the resident's record.

Operator/CMA B failed to ensure resident #110's health care service plan included the skilled nursing care to be provided and the name of the licensed nurse or agency responsible for providing the service and failed to ensure the licensed nurse providing the skilled nursing care

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documented the service and the outcome of the service in the resident's record.

- Record review for resident #150 revealed an admission date of 2/17/17 with diagnoses of paraplegia, hypertension, schizophrenia, and epilepsy.

Functional capacity screen dated 2/17/17 indicated resident was unable to perform management of medications and medical treatments.

Record contained a medical care provider's visit note dated 3/2/17 that documented plan for home health to visit for wound care.
A facility licensed nurse documented in the resident's record on 3/7/17 that home health began services of skilled nursing. The licensed nurse documented resident had a wound in perineal area measuring approximately 1 centimeter by 2 centimeters and 0.5 centimeter deep. Resident's record lacked further documentation of wound care and assessments or documentation of services provided by skilled nursing.

Negotiated service agreement/health care service plan dated 2/17/17 lacked the name of the home health provider and a description of services provided.

At 2:03 p.m. on 1/22/18, operator/CMA B provided home health skilled nursing visit notes dated 3/4/17, 3/13/17, 3/17/17, and 3/20/17. The skilled nursing notes did not indicate the wound healed and services discontinued.

Operator/CMA B failed to ensure resident #150's health care service plan included the skilled

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S5170	Continued From page 46 nursing care to be provided and the name of the licensed nurse or agency responsible for providing the service and failed to ensure the licensed nurse providing the skilled nursing care documented the service and the outcome of the service in the resident's record.	S5170		
S5185 SS=D	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. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(c) The facility reported a census of 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on record review, observation, and interview for 1 (#140) of 5 residents sampled, operator/certified medication aide (CMA) B failed to ensure a mechanical soft diet was prepared according to instructions from a medical care provider or licensed dietitian.	S5185		

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S5185	Continued From page 47 Findings included: - Record review for resident #140 revealed an admission date of 11/1/17 with diagnoses of history of stroke with left side hemiplegia, type 2 diabetes mellitus, hypertension, and atrial fibrillation. Functional capacity screen dated 11/1/17 indicated resident was independent with eating. Negotiated service agreement dated 11/1/17 documented resident to receive a mechanical soft diet. Resident's record contained a medical care provider's admission order for mechanical soft diet and also same diet ordered after resident returned from hospital stay on 1/5/18. At 12:07 p.m. on 1/22/18 observed operator/CMA B remove skin from a piece of fried chicken and then pull meat off of bone and placed meat in a blender. Operator/CMA B did not add gravy or liquid to chicken before grinding the meat in the blender. During an interview at 12:40 p.m. on 1/24/18, owner/licensed nurse D and operator/CMA B stated and confirmed staff did not have written instructions from a medical care provider or licensed dietitian for the preparation of a mechanical soft diet. Operator/CMA B failed to ensure resident #140 received a mechanical soft diet prepared by staff according to instructions from a medical care provider or licensed dietitian.	S5185		

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S5192	Continued From page 48	S5192		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(e) The facility reported a census of 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on observation and interview for all residents, operator/certified medication aide (CMA) B failed to ensure food was prepared using safe methods and served at the proper temperature. Findings included: - At 9:58 a.m. on 1/22/18, surveyor observed a 3.94 pound package of raw chicken leg quarters sitting in sink. Chicken in the original package from the grocery store. Surveyor touched plastic	S5192		

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wrap covering chicken and noted package was cool to the touch. Operator/CMA B stated he/she removed the chicken from the freezer at 9:30 p.m. last night and placed in sink to thaw. Operator/CMA B stated this chicken was to be prepared for today's lunch for residents. When surveyor asked operator/CMA B for policy and procedure to thaw foods, operator/CMA B stated take the food from freezer and sit it in the sink.

At 10:02 a.m. on 1/22/18, operator/CMA B checked the temperature of the raw chicken and obtained a reading of 72.5 degrees Fahrenheit. Surveyor informed operator this chicken was not safe to prepare and serve to residents due to being stored at unsafe temperature. Operator/CMA B threw the chicken in the trash. Operator/CMA B stated the facility did not have a written policy and procedure for safely thawing frozen foods.

At 9:45 a.m. on 1/24/18, surveyor observed 2 plates of scrambled eggs, fruit, and muffin sitting on kitchen counter to be served to residents. Operator/CMA B stated staff did not measure temperature of foods after cooking or before serving.

During an interview at 11:28 a.m. on 1/24/18, owner/licensed nurse D stated he/she could not find a policy and procedure for storing, thawing, preparing food, and serving food at proper temperature in the facility's policy and procedure manual. Owner/licensed nurse D stated he/she had e-mailed a policy and procedure for this to the operator/CMA B to keep in the facility.

Operator/CMA B failed to ensure food was prepared using safe methods and served to residents at the proper temperature.

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S5205 SS=K	26-42-104 (a) Disaster and Emergency Preparedness a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(a) The facility reported a census of 8 residents. The sample included 5 residents and 2 closed records. Based on interview, observation, and record review for 4 residents (#110, #150, #140, and #120) requiring two staff to transfer, operator/certified medication aide (CMA) B failed to ensure the provision of a sufficient number of staff on duty at all times to take residents who required two staff to transfer to a secure location in the event of an emergency or disaster. This failure placed residents in this facility in immediate jeopardy for harm, injury, or death. Findings included: - Review of the resident roster revealed residents #110, #150, #140, and #120 each required two-person transfer assistance. Observations on 1/22/18 revealed residents #180 and #190 required one-person transfer assistance and residents #130 and #200 were independent with ambulation. The roster documented that each of the 8 residents experienced impaired cognition. During an interview at 11:10 a.m. on 1/22/18 operator/CMA B stated there were 2 staff on duty	S5205		

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at all times. Operator/CMA B provided documentation of an emergency drill with evacuation dated 10/6/17 and 11/5/17. The documents did not include the number of staff participating in each drill and the time it took to evacuate all residents from the building. Operator/CMA stated 2 staff conducted each drill and he/she knew the last drill took staff 9 minutes and 10 seconds to evacuate residents out of facility. Operator/CMA B stated the facility did not have a fire sprinkler system. Operator/CMA B stated 6 residents (#110, #120, #180, #190, #150, and #140) required a wheelchair for mobility and 4 of these residents (#110, #120, #150, and #140) required 2 staff members to transfer to a wheelchair.

- Record review for resident #110 revealed an admission date of 1/23/15 with diagnoses of history of stroke with left side affected, chronic schizoaffective disorder, type 2 diabetes mellitus, and hypertension.

Functional capacity screen dated 7/26/17 indicated resident was unable to perform transferring and mobility, experienced impaired decision making, and required a wheelchair for mobility and a mechanical lift for transferring.

Negotiated service agreement dated 12/4/17 documented total assistance to transfer with 2 staff members using a sit-to-stand lift.

At 1:00 p.m. on 1/22/18, surveyor observed certified staff C and certified staff E transfer resident #110 from wheelchair to bed using a sit-to-stand lift. Surveyor observed resident unable to bear weight on left leg.

- Record review for resident #150 revealed an

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admission date of 2/17/17 with diagnoses of paraplegia, hypertension, schizophrenia, and epilepsy.

Functional capacity screen dated 2/17/17 indicated resident was unable to perform transferring and mobility, required a wheelchair for mobility, and experienced impaired short term memory, long term memory, memory recall, and decision making.

Negotiated service agreement dated 2/17/17 documented resident to receive total assistance to transfer and two-person assistance for mobility in wheelchair.

During an interview at 1:33 p.m. on 1/24/18, certified staff C stated resident required two staff members to transfer.

- Record review for resident #140 revealed an admission date of 11/1/17 with diagnoses of stroke with left side hemiplegia, type 2 diabetes mellitus, atrial fibrillation, and hypertension.

Functional capacity screen dated 11/1/17 indicated resident was unable to perform transferring and mobility, required a Hoyer lift and two-person transfer assistance, a wheelchair for mobility, and experienced impaired long term memory and memory recall.

Negotiated service agreement dated 11/1/17 documented total assistance of 2 staff to transfer, may use Hoyer lift as needed, and wheelchair for mobility.

During an interview at 1:43 p.m. on 1/24/18, certified staff C stated and confirmed resident required a two-person transfer.

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S5205	Continued From page 53 - Record review for resident #120 revealed an admission date of 12/16/16 with diagnoses of dementia, atrial fibrillation, and stroke. Functional capacity screen dated 12/16/16 indicated resident required physical assistance with transferring, was independent with mobility, utilized a walker for mobility, and experienced impaired long term memory, memory recall, and decision making. Record lacked a more recent functional capacity screen. Negotiated service agreement dated 12/14/17 documented resident to receive two-person transfer assistance, use sit-to-stand lift, and wheelchair for mobility. At 12:29 p.m. on 1/24/18, owner/licensed nurse D stated resident currently in hospital due to possible stroke. The time clock records for 10 employees and payroll details report from 11/13/17 through 1/21/18 were compared. The documents provided lacked a time card record for all of the hours worked for certified staff F for the pay period of 1/8/18 to 1/21/18; time card documented 5:46 a.m. 1/9/18 to 7:37 a.m. 1/10/18 and 6:56 p.m. 1/10/18 to 7:38 a.m. 1/11/18 and the payroll details report showed he/she was paid for 26 hours regular and 56 hours nights. The records also lacked a time card record showing the dates and times certified staff G worked during the pay period of 11/13/17 to 11/26/17 when he/she was paid for 29 regular hours. The records lacked time clock records or any other documentation showing dates and times operator/CMA B worked at the facility and documented the following hours paid: 11/13/17 to	S5205		

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11/26/17 66 hours regular, 24 hours nights; 11/27/17 to 12/10/17 80 hours regular, 38 hours overtime, 8 hours nights; 12/11/17 to 12/24/17 80 hours regular, 67 hours overtime, 24 hours nights; 12/25/17 to 1/7/18 80 hours regular, 78 hours overtime, 32 hours nights; and 1/8/18 to 1/21/18 80 hours regular, 88 hours overtime, and 32 hours nights. All other payroll detail reports matched the hours listed on the time card records.

Review of these records failed to demonstrate 2 staff on duty on the following dates and times:

11/13/17 7 a.m. to 2 p.m.; 4 p.m.to 11 p.m.
11/14/17 8 a.m. to 6 p.m.
11/16/17 8 a.m. to 5 p.m.
11/17/17 8 a.m. to 3 p.m.
11/18/17 8 a.m. to midnight
11/19/17 midnight to midnight
11/20/17 midnight to 5 p.m.
11/21/17 8 .m. to 3 p.m.; 5 p.m. to 9 p.m.
11/22/17 7 a.m. to midnight
11/23/17 midnight to 3 p.m.
11/24/17 9 a.m. to 3 p.m.
11/26/17 7 a.m. to 7 p.m.
11/27/17 11 a.m. to midnight
11/28/17 midnight to 7 p.m.
11/29/17 8 a.m. to 6 p.m.
11/30/17 8 a.m. to noon; 2p.m. to 5 p.m.

12/1/17 10 p.m. to 11 p.m.
12/2/17 7 a.m. to 3 p.m.; 5 p.m. to 11 p.m.
12/3/17 8 a.m. to 3 p.m.
12/4/17 7 a.m. to 6 p.m.
12/5/17 8 a.m. to 3 p.m.
12/6/17 8 a.m. to 11 a.m.; 6 p.m. to 11 p.m.
12/7/17 7 a.m. to 2 p.m.;11 p.m. to midnight
12/8/17 midnight to 7 a.m.; 4 p.m. to midnight
12/11/17 7 a.m. to 11 p.m.

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	B087137	A. BUILDING: _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS OF WICHITA LLC	6311 E MARJORIE ST 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
S5205	Continued From page 55 12/12/17 7 a.m. to 6 p.m. 12/13/17 7 a.m. to 7 p.m. 12/14/17 7 a.m. to 7 p.m. 12/15/17 8 a.m. to 10 a.m.; 11 p.m. to midnight 12/16/17 midnight to 3 p.m. 12/17/17 midnight to 3 p.m. 12/18/17 8 a.m. to 5 p.m. 12/19/17 8 a.m. to 3 p.m. 12/20/17 7 a.m. to 7 p.m. 12/21/17 7 a.m. to 7 p.m.; 11 p.m. to midnight 12/22/17 7 a.m. to 7 p.m. 12/24/17 11 p.m. midnight 12/25/17 midnight to 3 p.m. 12/27/17 7 a.m. to 7 p.m. 12/28/17 7 a.m. to noon; 4 p.m. to 7 p.m. 12/29/17 7 a.m. to noon; 4 p.m. to midnight 12/30/17 midnight to 3 p.m.; 11 p.m. to midnight 12/31/17 midnight to 3 p.m. 1/1/18 8 a.m. to 7 p.m. 1/2/18 8 a.m. to 3 p.m. 1/3/18 midnight to 8 a.m.; 4 p.m. to midnight 1/4/18 midnight to 2 p.m. 1/6/18 4 p.m. to 7 p.m. 1/8/18 7 a.m. to 3 p.m.; 4 p.m. to midnight 1/9/18 midnight to midnight 1/10/18 midnight to 9 a.m.; 1 p.m. to 7 p.m. 1/11/18 3 p.m. to 7 p.m. 1/12/18 7 a.m. to midnight 1/13/18 midnight to 3 p.m. 1/14/18 7 a.m. to 7 p.m.; 11 p.m. to midnight 1/15/18 midnight to 7 p.m. 1/16/18 midnight to 11 a.m.; 7 p.m. to midnight 1/17/18 midnight to midnight 1/18/18 midnight to 3 p.m.; 7 p.m. to midnight 1/19/18, 1/20/18 and 1/20/18 all shifts. The following dates and times lacked identification of the staff on duty:	S5205		

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S5205	Continued From page 56	S5205		

11/22/17 1 p.m. to 2 p.m.
11/23/17 7 a.m. to 11 p.m.
11/27/17 4 p.m. to 5 p.m.
11/28/17 5 p.m. to 7 p.m.
11/29/17 5 p.m. to 6 p.m.

12/4/17 5 p.m. to 6 p.m.
12/12/17 2 p.m. to 3 p.m.
12/13/17 5 p.m. to 7 p.m.
12/16/17 7 a.m. to 2 p.m.
12/22/17 4 p.m. to 5 p.m.
12/25/17 7 a.m. to 2 p.m.
12/27/17 6 p.m.to 7 p.m.
12/30/17 8 a.m. to 3 p.m.
12/31/17 7 a.m. to 3 p.m.

1/1/18 8 a.m. to 7 p.m.
1//10/18 6 p.m. to 7 p.m.
1/11/18 5 p.m. to 7 p.m.
1/12/18 7 a.m. to 3 p.m.
1/13/18 7 a.m. to 2 p.m.
1/14/18 7 a.m. to 4 p.m.; 6 p.m. to 7 p.m.
1/16/18 11 p.m. to midnight
1/17/18 midnight to 1 a.m.
1/20/18 2 p.m. to 4 p.m.

During a phone interview at 9:53 a.m. on 1/29/18, operator/CMA B stated he/she had no other documentation of employee timecards to provide.

Operator/CMA B failed to ensure the provision of a sufficient number of staff on duty at all times to take residents #110, #150, #140, and #120 who required two staff to transfer to a secure location in the event of an emergency or disaster.

The immediate jeopardy was removed at 4:20 p.m. on 1/25/18 when operator/CMA B provided a written plan of "As of 1/25/18 (facility) will have 2 staff 24 hours around the clock as well as will

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S5205	Continued From page 57 begin using time clock system to provide proof of staff attendance at all times."	S5205		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure 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 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on interview for all residents and all employees, operator/certified medication aide (CMA) B failed to ensure disaster and emergency preparedness by ensuring the performance of a quarterly review of the facility's emergency management plan with employees and residents. Findings included:	S5215		

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S5215	Continued From page 58 - During an interview at 11:16 a.m. on 1/22/18, operator/CMA B stated he/she had not conducted a quarterly review of the facility's entire emergency management plan with residents and employees. Operator/CMA B stated parts of the emergency management plan had been discussed but could not provide documentation of this. Operator/CMA B failed to ensure disaster and emergency preparedness by ensuring the performance of a quarterly review of the facility's emergency management plan with employees and residents.	S5215		
S5250 SS=D	26-42-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and	S5250		

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S5250	Continued From page 59 treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(6) The facility reported a census of 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on record review and interview for 1(#120) of 5 residents sampled, operator/certified medication aide (CMA) B failed to ensure the resident's record contained the admission negotiated service agreement. Findings included: - Record review for resident #120 revealed an admission date of 12/16/16 with diagnoses of dementia, atrial fibrillation, and history of stroke. Record contained a negotiated service agreement dated 12/14/17. The record lacked an admission negotiated service agreement or a negotiated service agreement dated prior to the 12/14/17 agreement. During an interview at 3:38 p.m. on 1/22/18, operator/CMA B stated and confirmed the admission negotiated service agreement should be in the resident's record. Operator/CMA B stated there was not an overflow file for this resident. Operator/CMA B failed to ensure resident #120's record contained the admission negotiated service agreement.	S5250		

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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 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on record review and interview for 1(#120) of 5 residents sampled, operator/certified medication aide (CMA) B failed to ensure the resident's record contained documentation of an incident and symptoms of illness or injury including the date, time of occurrence, action taken, and results of the action. Findings included: - Record review for resident #120 revealed an admission date of 12/16/16 with diagnoses of dementia, atrial fibrillation, and history of stroke. Functional capacity screen dated 12/16/16 indicated resident required supervision with eating; physical assistance with bathing, dressing, toileting, and transferring; was independent with mobility; and was unable to manage medications and medical treatments. Negotiated service agreement dated 12/14/17 documented facility staff provided physical	S5251		

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S5251	Continued From page 61 assistance with bathing, dressing, toileting, transferring, mobility, and administration of medications. At 12:14 p.m. on 1/22/18, surveyor observed resident #120 was not at the dining room table for lunch. Certified staff C stated resident was in the hospital due to a possible stroke. Resident's record lacked documentation on 1/21/18 of a licensed nurse assessment, resident's symptoms, and need for resident to be sent to hospital. During an interview at 3:15 p.m. on 1/22/18, operator/CMA B stated he/she had given resident's medication at 5:00 p.m. on 1/21/18 and it looked like resident got pills stuck in throat so operator/CMA B called emergency medical services and resident was transported and admitted to hospital with a possible stroke. Operator/CMA B stated he/she did not document the incident and action taken in the resident's record. Operator/CMA B failed to ensure resident #120's record contained documentation of an incident and symptoms of illness or injury including the date, time of occurrence, action taken, and results of the action.	S5251		
S5320 SS=D	26-42-205 (k) Medication Clinical Records (k) Clinical record. The administrator or operator, or the designee, shall ensure that the clinical record of each resident for whom the home manages the resident ' s medication or prefills medication containers or syringes contains the following documentation:	S5320		

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S5320	Continued From page 62 (1) A medical care provider ' s order for each medication; (2) the name of the pharmacy provider of the resident ' s choice; (3) any known medication allergies; and (4) the date and the 12-hour or 24-hour clock time any medication is administered to the resident. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(k)(1) The facility reported a census of 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on record review and interview for 1(#120) of 5 residents sampled, operator/certified medication aide (CMA) B failed to ensure the resident's record contained a medical care provider's order for Celexa (antidepressant) administered to the resident. Findings included: - Record review for resident #120 revealed an admission date of 12/16/16 with diagnoses of dementia, atrial fibrillation, and history of stroke. Functional capacity screen dated 12/16/16 indicated resident was unable to manage medications. Negotiated service agreement dated 12/14/17 documented facility staff administered medications to the resident.	S5320		

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S5320	Continued From page 63 Review of the January 2018 medication administration record revealed resident received Celexa 10 milligrams by mouth at 8:00 a.m. daily for depression and behaviors. Resident's record lacked a written medical care provider's order for this medication. During an interview at 12:29 p.m. on 1/24/18, owner/licensed nurse D stated and confirmed the resident's record lacked a written medical care provider's order for Celexa 10 milligrams by mouth daily. Operator/CMA B failed to ensure resident #120's record contained a medical care provider's order for Celexa administered to the resident.	S5320		
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 26-42-437(a) The facility reported a census of 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on observation and interview for all residents, operator/certified medication aide (CMA) B failed to ensure the facility was	S5335		

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S5335	Continued From page 64	S5335		

constructed, equipped, and maintained to protect the health and safety of residents, employees, and public.

Findings included:

- During tour of the facility with operator/CMA B at 9:19 a.m. on 1/22/18, surveyor observed the following:

Carpet tile in dining room by kitchen door curled up and unsecured to floor.

Metal poles on floor of a room directly west of dining room. Operator/CMA B stated this was a broken clothes rack. Operator/ CMA B stated this was the foyer area. This room was dark with 2 resident rooms and shower room only accessible through this room.
Operator/CMA B opened the door to resident #150's room and surveyor noted a strong foul odor in resident's room.

Laundry room accessible to residents with laundry soap and bleach in unlocked cabinet above washer. Laundry room with strong urine odor.

Shower room with rubber strip at base of shower not attached to the base and curved out on the vinyl floor.

Closet by front door and closet in east hallway packed with piles of clothing. Operator/CMA B stated clothing did not belong to current residents.

Flooring in front entrance covered with leaves, debris, and soiled.

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S5335	Continued From page 65 East hall bathroom with window cleaner. Tile countertop with chipped tile. Room of resident #110 with strong urine odor evident in hallway. Operator/CMA stated resident was incontinent of urine and he/she had just stripped bed. At 9:36 a.m. on 1/22/18, surveyor observed the following in the kitchen: Closet with key in doorknob stored cleaning chemicals. Unlocked cabinet under sink stored 3 bottles of dishwasher liquid, 1 gallon of bleach, and carpet cleaner. 3 holes in drywall on exterior wall in cabinet under cooktop. Lower cabinet door to left of cooktop with upper latch off and lower latch loose. Oven heavily soiled with burned on substance. Oven top soiled and crumbs on lip of oven door. All kitchen cabinets sanded to bare wood. Countertop tile chipped and large gap between countertop and backsplash. At 11:30 a.m. on 1/22/18, surveyor observed the same carpet tiles in the dining room, room directly west of dining room (foyer area), west hallway, back living room, east hallway, and resident rooms. Operator/CMA B stated these were 24 inch by 24 inch tiles and confirmed the tiles were not adhered to the floor and could	S5335		

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S5335	Continued From page 66	S5335		

easily be picked up. Surveyor observed that the carpet tiles did not fit securely up against the baseboards where dirt collected. Kitchen vinyl flooring and laundry room vinyl flooring curled and loose at baseboards.

At 12:00 p.m. on 1/23/18, surveyor observed the following in the backyard:

A metal shed without doors that held equipment, paint cans, and other items.

Wooden deck with loose boards that caused an uneven walking surface.

Trash and cigarette butts.

Surveyor observed that residents #130 and #200 were independent with ambulation. Each resident would go to the deck area to smoke unattended. Resident #130 spent time outside sweeping the deck. Resident roster listed each of the 8 residents with impaired cognition.

During an interview at 11:12 a.m. on 1/24/18, owner/licensed nurse D stated he/she leased the property and the owner of the property would not pay for any upkeep. Owner/licensed nurse D observed all of the above issues and confirmed the needed maintenance.

At 4:23 p.m. on 1/25/18, certified staff C and certified staff E transferred resident #180 and #190 each from a recliner to a wheelchair in the front living room. Resident #200 got up from recliner in same room and ambulated to his/her bedroom. Surveyor noted strong odor of urine and feces and observed each seat cushion of the 3 recliners discolored and covered with what appeared to be food crumbs.

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S5335	Continued From page 67 For all residents, operator/CMA B failed to ensure the facility was constructed, equipped, and maintained to protect the health and safety of residents, employees, and public.	S5335		
S5380 SS=F	28-39-437 Plumbing and Piping Systems (i) Plumbing and piping systems. (1) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (2) Water distribution systems shall be arranged to provide hot water at hot water outlets at all times. The temperature of hot water shall range between 98° F and 120° F at showers, tubs, and lavatories accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(i)(2) The facility reported a census of 8 residents. The sample included 5 residents and 2 closed records reviewed. Based on observation, interview, and record review for all residents, Operator/certified medication aide (CMA) B failed to ensure a system to monitor and maintain a hot water temperature range between 98 degrees Fahrenheit (F) and 120 degrees F at showers, lavatories, and kitchen sink accessible to residents. Findings included: - At 10:10 a.m. on 1/22/18, surveyor began measuring hot water temperatures and obtained the following readings:	S5380		

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 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS OF WICHITA LLC	6311 E MARJORIE ST 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
S5380	Continued From page 68 120.2 degrees F from the kitchen sink 127.7 degrees F from the half bath sink off the laundry room accessible to residents 131.7 degrees F from the east bathroom sink 131 degrees F from the bathroom sink in resident #140 and resident #120's shared room 129 degrees F from shower room sink. At 10:46 a.m. on 1/22/18, operator/CMA B stated hot water temps were to be monitored 2 times a week and provided a notebook with records of the readings. The records documented hot water temperature reading with the most recent temperature for the kitchen sink on 12/1/17; half bath sink 11/6/17; shower room 11/3/17; and bathroom sink in resident bedroom on 11/6/17. Surveyor asked operator/CMA B to adjust hot water tank thermostat to bring hot water temperature between 98 degrees F and 120 degrees F. Operator/CMA B stated he/she would call the company that installed the hot water tank. At 11:19 a.m. on 1/22/18, certified staff C stated (resident #130 and resident #200) were independent with toileting and he/she would supervise these residents when they washed their hands after toileting. At 11:23 a.m. on 1/22/18, 2 people working for the company that installed the hot water tank arrived, went to the basement, turned the thermostat from the hot setting to warm setting on the tank; and instructed operator/CMA B to run hot water to lower the hot water temperature.	S5380		

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S5380	Continued From page 69 During an interview at 11:30 a.m. on 1/24/18, owner/licensed nurse D stated hot water temperatures were to be measured and recorded one time a week. Owner/licensed nurse D stated he/she could not find a policy and procedure to monitor and maintain hot water temperatures in the required range. Operator/CMA B failed to ensure a system to monitor and maintain a hot water temperature range between 98 degrees Fahrenheit (F) and 120 degrees F at showers, lavatories, and kitchen sink accessible to residents.	S5380		