STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087119	A. BUILDING: _____ B. WING _____	12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING BY WARDEN LLC	234 S ANNA STREET WICHITA, KS 67209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey of the above home plus facility on 11/29/18, 12/3/18, and 12/4/18.	S 000		
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 11 residents. The sample included 3 residents and 1 resident focus reviewed. Based on record review, interview, and observation for 3 (#108, #111, and #110) of 3 residents sampled and 1 (#109) of 1 resident focus reviewed, operator B failed to ensure a licensed nurse provided or coordinated the 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 #108 revealed an admission date of 8/5/15 with diagnoses of type 2 diabetes mellitus, right below knee amputation,	S5155		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087119	A. BUILDING: _____ B. WING _____	12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING BY WARDEN LLC	234 S ANNA STREET WICHITA, KS 67209

(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
S5155	Continued From page 1 congestive heart failure, and chronic obstructive pulmonary disease. Functional capacity screen dated 10/16/18 indicated resident was unable to perform bathing, dressing, toileting, and transferring; required physical assistance with mobility; was incontinent of urine; experienced impaired memory recall and decision making; and required mobility devices of a mechanical lift and a wheelchair. Negotiated service agreement/health care service plan (NSA/HCSP) dated 10/16/18 documented staff members to provide total assistance with bathing, dressing, toileting, incontinence care, transferring with a mechanical lift and 2 staff members, and mobility in wheelchair. At 1:42 p.m. on 11/29/18, surveyor observed certified staff F and certified staff J transfer resident #108 in the resident's room with a sit-to-stand lift from wheelchair to toilet. Surveyor observed a half side rail in the raised position on the side of the resident's bed that was against the wall and a half side rail propped up against the wall beside the bed. During an interview at 2:52 p.m. on 11/29/18, certified staff J stated resident required the use of the side rails to help with turning in bed while a staff member provided care to resident. Resident's NSA/HCSP lacked a description of resident's need for and use of side rails. Resident's record lacked an assessment of the safety of the side rails and resident's ability to safely use the side rails. During an interview at 12:23 p.m. on 12/3/18, licensed nurse C stated and confirmed resident's	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087119	A. BUILDING: _____ B. WING _____	12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING BY WARDEN LLC	234 S ANNA STREET WICHITA, KS 67209

(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
S5155	Continued From page 2 NSA/HCSP lacked a description of resident's need for and use of side rails and the resident's record lacked an assessment of the safety of the side rails and resident's ably to safely use the side rails. Licensed nurse C stated resident would require total assistance to exit the building in an emergency and the NSA/HCSP did not describe staff assistance required for this. Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #108 and were in accordance with the functional capacity screening and the negotiated service agreement. - Record review for resident #111 revealed an admission date of 11/7/16 with diagnosis of Alzheimer's disease. Functional capacity screen dated 8/7/18 indicated resident was unable to transfer or mobilize self; required a wheelchair and mechanical lift to assist with mobility; and experienced impaired short-term memory, long-term memory, memory recall, and decision making. Negotiated service agreement/health care service plan (NSA/HCSP) dated 8/7/18 documented resident required 2 staff members and a mechanical lift to transfer and mobilized in a wheelchair. At 1:21 p.m. on 11/29/18, in the resident's room, surveyor observed certified staff J and certified staff F transfer resident from wheelchair to bed using a Hoyer lift. Resident was dependent on the 2 staff members during the transfer and 1 staff member to position resident in bed. Resident's NSA/HCSP did not address resident's	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087119	A. BUILDING: _____ B. WING _____	12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING BY WARDEN LLC	234 S ANNA STREET WICHITA, KS 67209

(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
S5155	Continued From page 3 immobility and assistance required to exit the building in an emergency. During an interview at 12:55 p.m. on 12/3/18, licensed nurse C stated resident was immobile and would require total assistance to exit the building in an emergency. Licensed nurse C stated resident's NSA/HCSP did not describe how resident would exit the building. Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #111 and were in accordance with the functional capacity screening and the negotiated service agreement. - Record review for resident #110 revealed an admission date of 11/13/18 with diagnoses of type 2 diabetes mellitus and dementia. Functional capacity screen dated 11/13/18 indicated resident required physical assistance with bathing, dressing, toileting, transferring and mobility; required assistive devices of a walker and wheelchair; was frequently incontinent of urine; and experienced impaired short-term memory, memory recall, and decision making. Negotiated service agreement/health care service plan (NSA/HCSP) dated 11/13/18 documented facility staff assisted resident with dressing, toileting, assistance with incontinence care, and transfer and ambulation assistance by one staff member using a gait belt and a walker and wheelchair as needed. At 11:55 a.m. on 12/3/18, surveyor observed an assistive device attached to resident's bed. Resident's NSA/HCSP lacked a description of	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087119	A. BUILDING: _____ B. WING _____	12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING BY WARDEN LLC	234 S ANNA STREET WICHITA, KS 67209

(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
S5155	Continued From page 4	S5155		

resident's need for and use of a bed mobility device. Resident's record lacked an assessment of the safety of the device and resident's ability to safely use the device.

During an interview at 1:00 p.m. on 12/3/18, licensed nurse C stated and confirmed an assessment of the safety of the bed mobility device was not documented in the resident's record and the NSA/HCSP lacked a description of resident's need for and use of the device.

Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #110 and were in accordance with the functional capacity screening and the negotiated service agreement.

- Record review for resident #109 revealed an admission date of 11/27/18 with diagnoses of history of spinal stenosis, chronic back pain, recent laminectomy surgical procedure, and type 2 diabetes mellitus.

Functional capacity screen dated 11/27/18 indicated resident #109 required physical assistance with transferring and mobility; utilized a walker or wheelchair; and experienced impaired short-term memory, memory recall, and decision making.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 11/27/18 documented two staff members to assist with gait belt for resident to stand/pivot transfer, may use Hoyer (mechanical) lift as needed for weakness, and wheelchair for mobility. Aide care plan dated 11/27/18 documented use of sit-to-stand lift as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087119	A. BUILDING: _____ B. WING _____	12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING BY WARDEN LLC	234 S ANNA STREET WICHITA, KS 67209

(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
S5155	Continued From page 5 At 12:30 p.m. on 12/3/18, surveyor observed certified staff J and another certified staff transfer resident with a sit-to-stand lift from wheelchair to a recliner in living room. Surveyor observed that resident was dependent on staff for mobility. The NSA/HCSP did not address resident's need for immobility and total assistance to exit the building. During an interview at 12:49 p.m. on 12/3/18, licensed nurse C stated resident would require total assistance to exit building in an emergency. Licensed nurse C confirmed the NSA/HCSP did not document services to ensure resident would receive physical assistance to exit the building. Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #109 and were in accordance with the functional capacity screening and the negotiated service agreement.	S5155		
S5205 SS=F	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 11 residents.	S5205		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087119	A. BUILDING: _____ B. WING _____	12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING BY WARDEN LLC	234 S ANNA STREET WICHITA, KS 67209

(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 6 The sample included 3 residents and 1 resident focus reviewed. Based on record review, interview, and observation for all residents, operator B failed to 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. Findings included: - During an interview at 10:51 a.m. on 11/29/18, operator B stated a staffing pattern of 2 certified employees on duty on each of the 3 shifts. Operator B stated an emergency drill with evacuation of residents on 8/24/18 by 5 staff members assisting 10 residents with a documented time of 3 minutes to complete and an evacuation drill on 10/10/17 completed by 6 staff members to take 12 residents to a secure location in 3 minutes and 48 seconds. Operator B stated he/she did not have documentation of an emergency drill with evacuation of residents to a secure location by 2 staff members. Review of the resident roster revealed residents #108, #109, and #111 each required 2 staff members to transfer and 9 residents experienced impaired cognition. During time in the facility on 11/29/18 and 12/3/18, surveyor observed 3 residents independent with ambulation. - Record review for resident #108 revealed an admission date of 8/5/15 with diagnoses of type 2 diabetes mellitus, right below knee amputation, congestive heart failure, and chronic obstructive pulmonary disease. Functional capacity screen dated 10/16/18 indicated resident was unable to transfer self; required use of a mechanical lift to transfer;	S5205		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087119	A. BUILDING: _____ B. WING _____	12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING BY WARDEN LLC	234 S ANNA STREET WICHITA, KS 67209

(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 7	S5205		

required physical assistance with mobility in wheelchair; and experienced impaired memory recall and decision making.

Negotiated service agreement/health care service plan dated 10/16/18 documented resident to receive transfer assistance from 2 staff members using a mechanical lift and 1 staff member to mobilize resident in wheelchair.

At 1:42 p.m. on 11/29/18, surveyor observed certified staff F and certified staff J transfer resident #108 in the resident's room with a sit-to-stand lift from wheelchair to toilet.

During an interview at 12:23 p.m. on 12/3/18, licensed nurse C stated resident #108 would require total assistance to exit the building in an emergency.

- Record review for resident #109 revealed an admission date of 11/27/18 with diagnoses of history of spinal stenosis, chronic back pain, recent laminectomy surgical procedure, and type 2 diabetes mellitus.

Functional capacity screen dated 11/27/18 indicated resident #109 required physical assistance with transferring and mobility; utilized a walker or wheelchair; and experienced impaired short-term memory, memory recall, and decision making.

Negotiated service agreement/health care service plan dated 11/27/18 documented two staff members to assist with gait belt for resident to stand/pivot transfer, may use Hoyer (mechanical) lift as needed for weakness, and wheelchair for mobility. Aide care plan dated 11/27/18 documented use of sit-to-stand lift as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087119	A. BUILDING: _____ B. WING _____	12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING BY WARDEN LLC	234 S ANNA STREET WICHITA, KS 67209

(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 8 At 12:30 p.m. on 12/3/18, surveyor observed certified staff J and another certified staff transfer resident with a sit-to-stand lift from wheelchair to a recliner in living room. During an interview at 12:49 p.m. on 12/3/18, licensed nurse C stated resident would require total assistance to exit building in an emergency. - Record review for resident #111 revealed an admission date of 11/7/16 with diagnosis of Alzheimer's disease. Functional capacity screen dated 8/7/18 indicated resident was unable to transfer or mobilize self; required a wheelchair and mechanical lift to assist with mobility; and experienced impaired short-term memory, long-term memory, memory recall, and decision making. Negotiated service agreement/health care service plan dated 8/7/18 documented resident required 2 staff members and a mechanical lift to transfer and mobilized in a wheelchair. At 1:21 p.m. on 11/29/18, in the resident's room, surveyor observed certified staff J and certified staff F transfer resident from wheelchair to bed using a Hoyer lift. During an interview at 12:55 p.m. on 12/3/18, licensed nurse C stated resident was immobile and would require total assistance to exit the building in an emergency. - Record review for resident #110 revealed an admission date of 11/13/18 with diagnoses of type 2 diabetes mellitus and dementia.	S5205		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087119	A. BUILDING: _____ B. WING _____	12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING BY WARDEN LLC	234 S ANNA STREET WICHITA, KS 67209

(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 9 Functional capacity screen dated 11/13/18 indicated resident required physical assistance with transferring and mobility; required assistive devices of a walker and wheelchair; and experienced impaired short-term memory, memory recall, and decision making. Negotiated service agreement/health care service plan dated 11/13/18 documented transfer and ambulation assistance by one staff member using a gait belt and a walker and wheelchair as needed. During time in facility on 11/29/18 and 12/3/18, surveyor observed one staff member assist resident to transfer to and from recliner using a gait belt and assist resident to walk with walker. Resident walked with an unsteady gait. During an interview at 1:30 p.m. on 12/3/18, maintenance director stated and confirmed he/she had not conducted an emergency drill with evacuation of residents to a secure location with only 2 staff members participating in the drill. Operator B failed to 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.	S5205		
S5258 SS=E	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087119	A. BUILDING: _____ B. WING _____	12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING BY WARDEN LLC	234 S ANNA STREET WICHITA, KS 67209

(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
S5258	Continued From page 10 specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(d)(3) The facility reported a census of 11 residents. The sample included 3 residents and 1 resident focus reviewed. Based on record review and interview for 4 of 4 certified employee files reviewed, operator B failed to ensure each file contained supporting documentation from the Kansas nurse aide registry that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home. Findings included: - Review of employee files at 3:47 p.m. on 11/29/18 with human resource director D revealed the following: Certified staff E hired 10/16/18	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087119	A. BUILDING: _____ B. WING _____	12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING BY WARDEN LLC	234 S ANNA STREET WICHITA, KS 67209

(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
S5258	Continued From page 11 Certified staff F hired 6/1/17 Certified staff G hired 10/16/18 Certified staff H hired 7/1/17 Each employee's file contained a printed Kansas nurse aide registry confirmation notice that lacked a print date as evidence the human resource director retrieved the documentation prior to the employee providing resident care in the facility. Operator B failed to ensure each file contained supporting documentation form the Kansas nurse aide registry that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home.	S5258		