Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087216	A. BUILDING: _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BOOMERS HOME PLUS, LLC	6953 E KENTFORD CIRCLE WICHITA, KS 67226

(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 revisit for correction order 18-167 of the above home plus facility on 11/14/18 and 11/15/18.	{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 6 residents. The sample included 3 residents. Based on observation, record review, and interview for 2 (#1010 and #1012) of 3 residents sampled, 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 (FCS)and the negotiated service agreement (NSA). Findings included: - During tour of facility at 9:34 a.m. on 11/14/18, surveyor observed the room of resident #1010 with a half rail in the raised position on one side of the resident's bed.	{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
	B087216	A. BUILDING: _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BOOMERS HOME PLUS, LLC	6953 E KENTFORD CIRCLE WICHITA, KS 67226

(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 Record review for resident #1010 revealed an admission date of 1/10/17 with diagnoses of senile degeneration of brain, type 2 diabetes mellitus, coronary artery disease, and hypertension. FCS dated 10/9/18 indicated resident required physical assistance with bathing, dressing, toileting, transferring, mobility with walker or wheelchair, and eating; was unable to perform management of medications and treatments; frequently incontinent of urine; experienced impaired short-term memory, long-term memory, memory recall, and decision making; was at risk for falls, and experienced impaired vision. NSA and health care service plan (HCSP) each dated 10/9/18 lacked a description of resident's need for and use of side rails when in bed. Record contained a side rail assessment dated 11/7/18 that documented bilateral side rails "indicated to serve as an enabler to promote independence." Nurse's notes contained an entry by a hospice nurse dated 10/23/18 of presence of a skin tear to resident's left forearm with an order to clean wound, apply topical antibiotic, apply skin-prep around area, and cover with bordered gauze every 3 days. The entry did not describe the cause of the skin tear. On 11/5/18, a hospice nurse documented resident's bilateral heels soft and red and applied skin barrier to each heel and left lower leg. The record contained a medical care provider's written order dated 10/18/18 for application of skin-prep to left second toe, allow to dry, and	{S5155}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087216	A. BUILDING: _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BOOMERS HOME PLUS, LLC	6953 E KENTFORD CIRCLE WICHITA, KS 67226

(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 apply 2 (inch) by 2 (inch) gauze daily until resolved. NSA/HCSP lacked a description of health care services to protect resident's skin to help prevent skin tears and breakdown. During an interview at 11:29 a.m. on 11/14/18, licensed nurse C stated hospice provided a new bed for resident with side rails. Licensed nurse C stated NSA/HCSP did not include a description of resident's need for and use of side rails when in bed. Licensed nurse D, when asked cause of resident's skin tear on arm, stated resident "bumps arms on things." Licensed nurse C stated the area on resident's toe had resolved and was caused by toes rubbing together. At 12:03 p.m. on 11/14/18, surveyor observed resident at table wearing a long-sleeved sweatshirt. Certified staff E stated the skin tear to resident's left forearm had healed. During an interview at 12:45 p.m. on 11/14/18, certified staff E listed interventions to protect resident's skin as apply barrier cream when providing incontinence care and toileting and keep long sleeves on resident. Certified staff E stated at one time resident had geri-sleeves to put on both arms but could no longer find the geri-sleeves. Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #1010 and were in accordance with the FCS and the NSA. - Record review for resident #1012 revealed an admission date of 9/8/18 with diagnoses of	{S5155}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087216	A. BUILDING: _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BOOMERS HOME PLUS, LLC	6953 E KENTFORD CIRCLE WICHITA, KS 67226

(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 dementia and chronic obstructive pulmonary disease. FCS dated 9/8/18 indicated resident required physical assistance with bathing, dressing, toileting, transferring, mobility with walker, and eating; unable to perform management of medications and treatments; frequently incontinent of urine; experienced impaired short-term memory, memory recall, and decision making; and was at risk for falls. NSA and health care service plan (HCSP) each dated 9/8/18 documented facility certified staff to assist resident with activities of daily living and provide peri-care due to urinary incontinence. Nurse's notes contained documentation by licensed nurse D dated 10/22/18 that staff reported resident had an open area on right intra-gluteal cleft. Licensed nurse D documented the area measured 1 centimeter in diameter, medical care provider notified, and staff instructed to apply Calmoseptine (skin barrier cream) to affected area. Record contained a written medical care provider's order dated 10/22/18 for Calmoseptine, apply topically to perineal area/buttock as needed for irritation. On 10/30/18 medical care provider changed the order to apply the Calmoseptine to buttocks three times a day and as needed. Resident's NSA/HCSP lacked a description of health care services to heal the resident's wound and to prevent further skin breakdown. On 11/14/18 at approximately 10:00 a.m., surveyor observed a home health nurse performing a skilled nursing assessment of the resident. Resident's NSA/HCSP lacked services	{S5155}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087216	A. BUILDING: _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BOOMERS HOME PLUS, LLC	6953 E KENTFORD CIRCLE WICHITA, KS 67226

(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 provided by a home health provider. Record contained a medical care provider's order dated 9/18/18 for home health physical therapy, occupational therapy, and speech therapy to evaluate and treat for deconditioning, muscle weakness, and chronic obstructive pulmonary disease. On 10/12/18 medical care provider ordered to discontinue the services of the home health provider and resident to receive physical therapy and occupational therapy from another home health provider. NSA/HCSP did not describe service provided by therapy. During an interview at 12:06 p.m. on 11/14/18, licensed nurse D stated resident received skilled nursing visits and exercises for strengthening from therapists. Licensed nurse D stated and confirmed the resident's NSA/HCSP lacked a description of services provided by home health. Licensed nurse D stated the NSA/HCSP lacked a description of health care services to address resident's risk for skin breakdown. During an interview at 12:47 p.m. on 11/14/18, when asked for interventions provided to prevent skin breakdown, certified staff E stated he/she toileted resident every 2 hours and applied skin barrier cream. Certified staff E stated physical therapy and occupational therapy walked with resident. Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #1012 and were in accordance with the FCS and the NSA.	{S5155}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087216	A. BUILDING: _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BOOMERS HOME PLUS, LLC	6953 E KENTFORD CIRCLE WICHITA, KS 67226

(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
S5171	Continued From page 5	S5171		
S5171 SS=E	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(i) The facility reported a census of 6 residents. The sample included 3 residents. Based on observation, record review, and interview for 2 (#1010 and #1012) of 3 residents sampled, operator B failed to ensure all health care services were provided to residents by qualified staff in accordance with acceptable standards of practice. Findings included: - Record review for resident #1010 revealed an admission date of 1/10/17 with diagnoses of senile degeneration of brain, type 2 diabetes mellitus, coronary artery disease, and hypertension. FCS dated 10/9/18 indicated resident required physical assistance with bathing, dressing, toileting, transferring, mobility with walker or wheelchair, and eating; was unable to perform management of medications and treatments; frequently incontinent of urine; experienced impaired short-term memory, long-term memory, memory recall, and decision making; was at risk for falls, and experienced impaired vision. Negotiated service agreement and health care service plan each dated 10/9/18 documented	S5171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087216	A. BUILDING: _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BOOMERS HOME PLUS, LLC	6953 E KENTFORD CIRCLE WICHITA, KS 67226

(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
S5171	Continued From page 6 certified staff provided physical assistance to resident to complete activities of daily living. Nurse's notes contained an entry by a hospice nurse dated 10/23/18 of presence of a skin tear to resident's left forearm with an order to clean wound, apply topical antibiotic, apply skin-prep around area, and cover with bordered gauze every 3 days. The entry did not describe the cause of the skin tear. On 11/5/18, a hospice nurse documented resident's bilateral heels soft and red and applied skin barrier to each heel and left lower leg. Resident's record lacked on-going nursing assessments of resident's impaired skin integrity. The record contained a medical care provider's written order dated 10/18/18 for application of skin-prep to left second toe, allow to dry, and apply 2 (inch) by 2 (inch) gauze daily until resolved. Resident's record lacked on-going nursing assessments of the condition of resident's toe. During an interview at 11:29 a.m. on 11/14/18, licensed nurse D stated he/she performed a monthly head-to-toe skin assessment of resident and these areas appeared after that assessment. Surveyor asked if licensed nurse performed a wound assessment at least weekly when the resident had wounds, licensed nurse D stated "We are at the mercy of our staff to report to us" condition of wound. Licensed nurse C stated he/she performed weekly wound assessment but did not document each assessment. Operator B failed to ensure all health care services were provided to resident #1010 by qualified staff in accordance with acceptable standards of practice.	S5171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087216	A. BUILDING: _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BOOMERS HOME PLUS, LLC	6953 E KENTFORD CIRCLE WICHITA, KS 67226

(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
S5171	Continued From page 7 - Record review for resident #1012 revealed an admission date of 9/8/18 with diagnoses of dementia and chronic obstructive pulmonary disease. Functional capacity screen dated 9/8/18 indicated resident required physical assistance with bathing, dressing, toileting, transferring, mobility with walker, and eating; unable to perform management of medications and treatments; frequently incontinent of urine; experienced impaired short-term memory, memory recall, and decision making; and was at risk for falls. Negotiated service agreement and health care service plan each dated 9/8/18 documented facility certified staff to assist resident with activities of daily living, provide peri-care due to urinary incontinence, and certified and licensed staff provided administration of medications and treatments. Nurse's notes contained documentation by licensed nurse D dated 10/22/18 that staff reported resident had an open area on right intra-gluteal cleft. Licensed nurse D documented the area measured 1 centimeter in diameter, medical care provider notified, and staff instructed to apply Calmoseptine (skin barrier cream) to affected area. Record contained a written medical care provider's order dated 10/22/18 for Calmoseptine, apply topically to perineal area/buttock as needed for irritation. On 10/30/18 medical care provider changed the order to apply the Calmoseptine to buttocks three times a day and as needed. Review of the October 2018 and the November 2018 medication administration records revealed	S5171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087216	A. BUILDING: _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BOOMERS HOME PLUS, LLC	6953 E KENTFORD CIRCLE WICHITA, KS 67226

(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
S5171	Continued From page 8 no documentation that Calmoseptine was applied to resident's wound as ordered. During an interview at 12:23 p.m. on 11/14/18, licensed nurse C stated resident's record lacked documentation that certified medication aides applied Calmoseptine as ordered. Operator B failed to ensure all health care services were provided to resident #1012 by qualified staff in accordance with acceptable standards of practice.	S5171		
{S5300} SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)	{S5300}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087216	A. BUILDING: _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BOOMERS HOME PLUS, LLC	6953 E KENTFORD CIRCLE WICHITA, KS 67226

(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
{S5300}	Continued From page 9 The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 1 (#1010) of 3 residents sampled, operator B failed to ensure that a medication was administered to the resident in accordance with a medical care provider's written order. Findings included: - Record review for resident #1010 revealed an admission date of 1/10/17 with diagnoses of senile degeneration of brain, hypertension, coronary artery disease, and type 2 diabetes mellitus. Functional capacity screen dated 10/4/18 indicated resident was unable to perform management of medications. Negotiated service agreement and health care service plan each dated 10/9/18 documented medication administration by licensed nurse and certified medication aides. The November 2018 medication administration record documented resident received Macrobid (antibiotic) 100 milligrams by mouth two times a day for 7 days from the 8:00 p.m. dose on 11/7/18 through the 8:00 a.m. dose on 11/14/18. The resident's record lacked a written medical care provider's order for the medication. The record contained a laboratory urinalysis with documentation signed by the medical care provider of an order given to hospice on 11/7/18. During an interview at 12:01 p.m. on 11/14/18, licensed nurse C contacted the resident's hospice nurse to ask about an order for Macrobid.	{S5300}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087216	A. BUILDING: _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BOOMERS HOME PLUS, LLC	6953 E KENTFORD CIRCLE WICHITA, KS 67226

(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
{S5300}	Continued From page 10 Licensed nurse C stated the hospice nurse had the medical care provider's order for the medication and would bring the order to the facility. Operator B failed to ensure that a medication was administered to resident #1010 in accordance with a medical care provider's written order.	{S5300}		