STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087215	A. BUILDING: _____ B. WING _____	R 11/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIST CARE HOME PLUS, LLC	7901 W JENNIE STREET WICHITA, KS 67212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	INITIAL COMMENTS The following citations represent the revisit correction order at the above named facility on 11/5/18, 11/7/18, 11/8/18, 11/13/18, and 11/14/18.	{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 26-204(a) The facility identified a census of 5 residents. The sample included 3 residents. Based on record review, observation, and interviews for 2 (#1222 and #1333) of 3 residents sampled, the operator/certified medication aide (CMA) failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that meet the needs of each resident and were in accordance with each resident's functional capacity screen (FCS) and negotiated service agreement (NSA). Findings included:	{S5155}		

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

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{S5155}	Continued From page 1 - Record review for resident #1222 revealed an admit date of 9/5/17 with diagnosis of dementia. The FCS dated 10/31/18 recorded resident unable to assist with bathing, dressing, toileting, transfer, walking/mobility, eating, lacked documentation for bladder incontinence cognition, and communication. The FCS further recorded resident experienced falls/unsteadiness, impaired vision, impaired hearing, and impaired decision making. The NSA/health care service plan (HCSP) dated 10/10/18 recorded bathing two times a week times two. Complete assistance with dressing, toileting, eating, must be fed as is blind. Resident no longer cooperative with ambulation and required physical assistance to wheel chair now. The NSA/HCSP lacked interventions to address the assistance required for transfer of resident #1222. The nurses notes recorded: 10/30/18 at 12:40 p.m. Resident at dinner table with blanket over head. Resident is blind and is now assisted with meals by staff and is no longer allowing staff to lead him/her for ambulation/transfer. Signed licensed nurse C. 11/4/18 at 3:45 p.m. Resident does not interact with hospice and does not allow them to assist	{S5155}		

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{S5155}	Continued From page 2 with bathing. No signs of skin break down. Signed licensed nurse C. Signed physician's orders dated 10/29/18 recorded resident to use sit to stand lift due to decreased mobility and increased weakness in bilateral legs. 11/5/18 at 12:20 p.m. observed resident #1222 sitting in wheel chair and attempting to stand up out of wheel chair. Certified staff D stated resident is blind and encouraged him/her to stay in wheel chair several times without decreased efforts. The record lacked an assessment of the resident ' s ability to safely use a sit to stand lift. 11/5/18 at 12:30 p.m. observed certified staff B and D physically assist resident #1222 from wheel chair to bedside commode. 11/5/18 at 12:40 p.m. observed operator/CMA A attempt to keep resident #1222 in wheel chair. Operator/CMA A stated resident had declined recently and became a two-person transfer. 11/5/18 at 1:05 p.m. observed a sit to stand lift at the end of resident #1222's bed. Certified staff D stated, "They are supposed to use the sit to stand lift on resident, but he/she will not hold on or attempt to stand with it."	{S5155}		

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{S5155}	Continued From page 3 11/5/18 at 2:00 p.m. observed resident #1222 attempting to get out of wheel chair at dining room table and operator/CMA came to stay with resident until certified staff D finished toileting resident #1333. Confidential interview on 11/5/18 stated had not been in-serviced or trained on how to use sit to stand lift. Resident #1222 and #1333 required physical assist of two for transfer and only one staff was on duty except at meal times. Operator/CMA wanted one staff to use sit to stand lift by self when alone on duty. Confidential interview on 11/7/18 stated resident #1222 and #1333 are two-person transfers. Was instructed by operator/CMA to use sit to stand lift and had not been trained or in-serviced on how to use it. Confidential interview on 11/7/18 stated resident #1333 was a two person transfer when he/she on duty at facility. Interview on 11/7/18 at 1:15 p.m. with licensed nurse C stated had two residents who on occasion required a two person assist and was not aware of a sit to stand lift being used in the facility. Operator/CMA A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that meet the needs of resident #1222 when he/she failed to	{S5155}		

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{S5155}	Continued From page 4 assessment resident ' s ability to safely use a sit to stand lift, train staff on proper use of the lift and describe interventions to be followed for safe transfer in the resident ' s NSA/HCSP. - Record review for resident #1333 revealed an admit date of 3/6/18 with diagnoses of dementia. The FCS dated 10/31/18 recorded resident required supervision for eating and unable to assist with bathing, dressing, toileting, transfer, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired decision making, and falls/unsteadiness. The NSA/HCSP dated 10/31/18 stated resident required physical assistance with bathing, dressing, toileting, required one to two-person assistance with transfer, used wheel chair for mobility, frequently uncooperative and 100%-wheel chair bound. Hospice staff to give resident bath two times a week. 10/10/18 Scoop mattress added on bed to prevent falls. The NSA/HCSP lacked interventions to address the assistance required for transfer of resident #1333. The nurses notes recorded on 10/30/18 resident remains "Uncooperative" in evenings and with commands by staff. " Resident is 100% disoriented."	{S5155}		

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{S5155}	Continued From page 5 Confidential interview on 11/5/18 stated resident #1333 required physical assist of two for transfer and one staff on duty except at meal times. Confidential interview on 11/7/18 stated resident #1333 is a two-person transfer. Confidential interview on 11/7/18 stated resident #1333 was a two person transfer when he/she on duty at facility. Interview on 11/7/18 at 1:15 p.m. with licensed nurse C stated resident #1333 on occasion required a two person assist and not sure if two staff on duty twenty-four hours a day seven day a week. Operator/CMA A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that meet the needs of resident #1333 when he/she failed to ensure the NSA/HCSP provided appropriate interventions for the safe transfer of resident #1333 For residents #1222 and #1333, the operator/CMA failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that meet the needs of each resident.	{S5155}		
{S5205} SS=J	26-42-104 (a) Disaster and Emergency Preparedness	{S5205}		

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{S5205}	Continued From page 6 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 identified a census of 5 residents. The sample included 3 residents. Based on record review, interviews and observations for all residents who experienced impaired cognition and for 2 (#1222 and #1333) of 3 residents who required two person assist for transfer, the operator/certified medication aide (CMA) failed to ensure the provision of sufficient number of staff to take residents who would require assistance in an emergency or disaster to a secure location when only 1 staff member was scheduled on duty. This failure placed residents in immediate jeopardy for harm, injury or death. Findings included: - At 12:20 p.m. on 11/5/18 arrived at facility and observed only certified staff D on duty. Certified staff D stated only had one staff on duty except at meal times when operator/CMA would come to facility and administer medications to residents. Certified staff D stated one resident was blind and two residents required two people to transfer. 11/5/18 at 12:45 p.m. observed certified staff D ambulate resident #1555 from dining room table to bathroom to toilet using gait belt and one staff assist.	{S5205}		

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{S5205}	Continued From page 7 Resident roster provided on 11/5/18 at 12:55 p.m. from operator/CMA identified resident #1222 required two-person assistance for transfer and all five residents experienced impaired cognition. Confidential interview stated staff had been instructed to use sit to stand lift for resident #1222 for transfer or two-person transfer. Interview on 11/5/18 at 1:35 p.m. with operator/CMA stated he/she had conducted fire evacuations with one staff on 10/8/18 at 11:00 a.m., 5:00 p.m. and 10:00 p.m. for all residents. Each evacuation was completed in three minutes. The operator/CMA stated all residents were up when the evacuation was conducted, and he/she had not conducted a fire evacuation when all residents were in bed or required transfer to a wheel chair before evacuation. Review of the documentation of the 10/8/18 evacuation drills document certified staff F participated in the 11:00 a.m. drill; certified staff E participated in the 5 p.m. drill and co-owner/certified staff B participated in the 10:00 p.m. drill. The documentation did not indicate the secure location the residents were evacuated to. Interview on 11/5/18 at 2:30 p.m. with operator/CMA stated had two staff here only at meal times. Confirmed resident #1222 required two-person transfer and resident #1333 required two-person transfer when combative. Interview on 11/7/18 with certified staff D stated he/she had not participated in any evacuation drills. Certified staff D further stated he/she felt could not safely evacuate all residents safely to a secure location by himself/herself.	{S5205}		

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{S5205}	Continued From page 8 Interview on 11/7/18 with certified staff E stated had participated with one evacuation when all residents were up in wheel chairs and operator/CMA assisted. Certified staff E further stated felt he/she could not safely evacuate all residents by self to a secure location. Interview on 11/7/18 with certified F stated had participated in an evacuation with all residents up in living room in wheel chairs and had not participated in an evacuation when residents were in bed. Certified staff F stated did not feel like he/she could safely evacuate all residents by self to a secure location. - Record review for resident #1222 revealed an admit date of 9/5/17 with diagnosis of dementia. The FCS dated 10/31/18 recorded resident unable to assist with toileting, transfer, walking/mobility. The FCS lacked documentation for cognition and communication. The FCS further recorded resident experienced falls/unsteadiness, impaired vision, impaired hearing, and impaired decision making. The NSA/health care service plan (HCSP) dated 10/10/18 recorded Complete assistance with toileting. Resident no longer cooperative with ambulation and required physical assistance to wheel chair now. The NSA/HCSP lacked interventions to address the assistance required for transfer of resident #1222. The nurses notes recorded:	{S5205}		

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{S5205}	Continued From page 9 10/30/18 at 12:40 p.m. Resident at dinner table with blanket over head. Resident is blind and is now assisted with meals by staff and is no longer allowing staff to lead him/her for ambulation/transfer. Signed licensed nurse C. Signed physician's orders dated 10/29/18 recorded resident to use sit to stand lift due to decreased mobility and increased weakness in bilateral legs. (Note: Resident must be able to bear weight to use a sit to stand lift) On 11/5/18 at 12:30 p.m. observed certified staff B and D physically assist resident #1222 from wheel chair to bedside commode. During transfer, resident #1222 did not bear weight and was uncooperative. On 11/5/18 at 12:40 p.m. observed operator/CMA A attempt to keep resident #1222 in wheel chair. Operator/CMA A stated resident had declined recently and became a two-person transfer. On 11/5/18 at 1:05 p.m. observed a sit to stand lift at the end of resident #1222's bed. Certified staff D stated, "They are supposed to use the sit to stand lift on resident, but he/she will not hold on or attempt to stand with it." Confidential interview on 11/5/18 stated had not been in-serviced or trained on how to use sit to stand lift. Resident #1222 required physical	{S5205}		

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{S5205}	Continued From page 10 assist of two for transfer and only one staff was on duty except at meal times. Operator/CMA wanted one staff to use sit to stand lift by self when alone on duty. Confidential interview on 11/7/18 stated resident #1222 are two-person transfers. Was instructed by operator/CMA to use sit to stand lift and had not been trained or in-serviced on how to use it. Confidential interview on 11/7/18 stated resident #1222 was a two person transfer when he/she on duty at facility. - Record review for resident #1333 revealed an admit date of 3/6/18 with diagnoses of dementia. The FCS dated 10/31/18 recorded resident unable to assist with toileting, transfer, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired decision making, and falls/unsteadiness. The NSA/HCSP dated 10/31/18 stated resident required physical assistance with toileting, required one to two-person assistance with transfer, used wheel chair for mobility, frequently uncooperative and 100%-wheel chair bound. The nurses notes recorded on 10/30/18 resident remains "Uncooperative" in evenings and with commands by staff. " Resident is 100% disoriented."	{S5205}		

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{S5205}	Continued From page 11 Confidential interview on 11/5/18 stated resident #1333 required physical assist of two for transfer and one staff on duty except at meal times. Confidential interview on 11/7/18 stated resident #1333 is a two-person transfer. Confidential interview on 11/7/18 stated resident #1333 was a two person transfer when he/she on duty at facility. Interview on 11/7/18 at 1:15 p.m. with licensed nurse C stated had two residents who on occasion required a two person assist and was not aware of a sit to stand lift being used in the facility. 11/7/18 at 12:15 p.m. Operator/CMA identified a staffing spiral notebook with time hand written that identified who worked each shift daily. The staffing notebook lacked documentation to indicate anyone worked on the 10:00 p.m. to 6:00 a.m. shift. Operator/CMA stated he/she and co-owner/certified staff B did not record hours worked as they owned the facility and co-owner/certified staff B worked the night shift. For all residents who experienced impaired cognition and for residents #1222 and #1333 who required two-person assist for transfer, the operator/CMA failed to ensure the provision of sufficient number of staff to take residents who would require assistance in an emergency or disaster to a secure location when only 1 staff	{S5205}		

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{S5205}	Continued From page 12 member on duty. The failure placed residents in immediate jeopardy for harm, injury or death. The jeopardy was removed on 11/7/18 at 2:15 p.m. when operator/CMA provided a written plan/policy that recorded "will employee two staff to work each shift in order to deliver proper protection and care of residents. This will ensure that in case of any emergency, safe evacuations will be performed."	{S5205}		