STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087046S	A. BUILDING: _____ B. WING _____	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK WEST PLAZA	505 N MAIZE ROAD 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 findings of a resurvey with a complaint (#122643) at the above named assisted living facility conducted on 10/16,22,23/2018.	S 000		
S3090 SS=E	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(c) The facility reported a census of 64 residents. The sample included 6 residents. Based on interview and record review the administrator failed to ensure designated staff developed an initial negotiated service agreement at admission for 3 (#101, #102, and #104) of 6 residents. Findings included: - Review of resident #101's record revealed he/she admitted to the facility on 7/31/17 with hypertension, anxiety, dementia, and osteoarthritis. Review of the functional capacity screen dated 7/24/17 revealed the resident required physical assistance with bathing, dressing, walking and management of medications and treatments. The resident also had bladder incontinence and problems/risk of falls/unsteadiness.	S3090		

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
	N087046S	A. BUILDING: _____ B. WING _____	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK WEST PLAZA	505 N MAIZE ROAD 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
S3090	Continued From page 1 Review of the negotiated service agreement dated 7/31/17 revealed facility staff signed the agreement on 7/31/18 but the resident signed it on 8/7/17, 1 week after admission. - Review of resident #102's record revealed he/she admitted to the facility on 4/12/18 with diagnosis of hypertension, depression, reflux disease, and breast cancer. Review of the functional capacity screen dated 4/13/18 revealed the resident required physical assistance from staff with bathing, dressing, toileting, transfers, walking, and management of medications and treatments. The resident also had bladder incontinence, cognitive deficits and risk for falls/unsteadiness. Review of the negotiated service agreement dated 4/13/18 included facility staff signatures on 4/13/18 but was signed by a family member on 4/16/18, 3 days after admission. - Review of resident #104's record revealed the resident admitted to the facility on 7/26/18 with diagnosis of glaucoma and hypertension. Review of the functional capacity screen dated 7/26/18 revealed the resident was independent in ADLs. Review of the negotiated service agreement dated 7/26/18 revealed the facility staff signed the negotiated service agreement on 7/26/18 and the resident's responsible party signed the agreement on 7/27/18, 1 day after admission. During an interview on 10/23/18 at 9:41 AM administrative nursing staff B confirmed the	S3090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087046S	A. BUILDING: _____ B. WING _____	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK WEST PLAZA	505 N MAIZE ROAD 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
S3090	Continued From page 2 admission negotiated service agreements for resident #101, #102, and #104 did not get signed by the resident or resident representative on the day of admission. The administrator failed to ensure designated staff developed an initial negotiated service agreement upon admission for 3 residents.	S3090		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires 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 care home; 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 have worked as a certified nurse aide.	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087046S	A. BUILDING: _____ B. WING _____	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK WEST PLAZA	505 N MAIZE ROAD 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
S3248	Continued From page 3 This REQUIREMENT is not met as evidenced by: KAR-26-41-102 (d)(1)(2) The facility reported a census of 64 residents. The sample included 6 residents. Based on interview and record review, the administrator failed to ensure 2 of 5 employee records contained certification verification information upon hire. This had the potential to affect all residents in the facility. Findings included: - Review of employee files conducted the morning of 10/22/18 revealed the following: Certified nursing staff D - hired on 8/17/18 with a registry certification check completed on 8/23/18, 6 days after hire. Certified nursing staff E - hired on 9/10/18 with a registry certification check completed on 10/16/18, 36 days after hire. An interview on 10/22/18 at 9:30 AM administrative staff A reported someone applied on line, are interviewed, and if an offer is made they signed paperwork . Staff A reported registry checks and criminal background checks are typically done prior to completing new hire paperwork. The administrator failed to ensure employee records contained licensure or certification verification information upon hire. This had the potential to affect all residents in the facility	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087046S	A. BUILDING: _____ B. WING _____	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK WEST PLAZA	505 N MAIZE ROAD 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
S3280	Continued From page 4	S3280		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (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 facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' 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 26-41-104(d)(3) The facility reported a census of 64. The sample included 6 residents. Based on record review and interview for all residents and all facility employees, the administrator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with employees and residents. Findings included: - Review of the information provided by administrative staff A on 10/22/18 at 12:00 PM	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087046S	A. BUILDING: _____ B. WING _____	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK WEST PLAZA	505 N MAIZE ROAD 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
S3280	Continued From page 5 revealed the facility reviewed the emergency management plan on 11/10/17 with facility staff. Staff had no other record of review of the emergency management plan with staff. During an interview on 10/16/18 at 3:04 PM administrative staff A reported he/she could not find record of quarterly reviews of the emergency management plan with residents and staff but would look in resident council minutes to see if the review had been conducted. During an interview on 10/23/18 at 11:30 AM life enrichment staff C reported he/she assisted with conducting resident council meetings and since February of 2018 when he/she hired on the emergency management plan had not been reviewed during resident council. For all residents and employees, the administrator failed to ensure emergency preparedness by ensuring quarterly review of the emergency management plan with all staff and residents.	S3280		