STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087210	A. BUILDING: _____ B. WING _____	R-C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD SENIORS, LLC	1226 S BYRON ROAD 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
R9999	FINAL COMMENTS SS=F K.S.A. 39-938 Adult care homes shall comply with all the lawfully established requirements and rules and regulations of the secretary of aging, and the state fire marshal and any other agency of government so far as pertinent and applicable to adult care homes, their buildings, operators, staffs, facilities, maintenance, operation, conduct and the care and treatment of residents. This requirement is not met as evidenced by: The census equaled 4 the sample include 3 residents. Based on interviews, and reviews of records, for all residents, the facility failed to ensure the federal HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule that required appropriate administrative and physical safeguards be in place to protect the privacy of Resident records containing protected health information when Resident records were were kept in an attached garage and accessible to non-employed people that were allowed free access to the garage. - Observation on 10/25/18 at 9:30 AM resident records were kept on a shelf in the garage that could be accessible by any person that went into the garage. During an interview on 10/25/18 at 10:33 AM certified staff reported Person C was supposed to be an assistant or something but doesn't have a license so he/she does not do anything with the resident's but comes in and tells the staff how to take care of the resident's. At 10:55 AM staff A reported Person C was at the facility working in the office (garage) when he/she came to work at	R9999		

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

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R9999	Continued From page 1 7:00 AM. During an interview on 10/25/18 at 11:50 AM administrative staff B reported Person C helps staff B with the books, asking if he/she has the correct forms for different things. Staff B stated Person C will just pop in and doesn't have a schedule when he/she comes. Staff B stated he/she thought Person C was last at the facility a couple of days ago. Staff B stated he/she had spoke with Person C about making sure he/she kept resident information private and safe. Staff B confirmed the personal health information is not locked up and that Person C would have access to resident protected health information in the garage if he/she wanted it. For all Residents, the Operator failed to ensure appropriate administrative and physical safeguards were in place to protect the privacy of Resident records containing protected health information, in accordance with federal HIPAA Privacy Rule, when Resident records were place in the garage and Person C allowed to be in the garage without supervision.	R9999		
{S 000}	INITIAL COMMENTS The following citations represent the findings of a revisit at the above named Home Plus living facility conducted on 10/25/18.	{S 000}		
{S5185} SS=E	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	{S5185}		

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{S5185}	Continued From page 2 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(a)(c) The facility reported a census of 4 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to provide dietary services to 2 (#50, #80) of 3 residents as identified in their negotiated service agreement and failed to ensure a medical care providers order for therapeutic diet and instructions on how to prepare the therapeutic diet. Findings included: - review of resident #50's record revealed he/she admitted to the facility on 11/1/17 with diagnoses of bone cancer, schizophrenia, and Alzheimer's disease. Review of the functional capacity screen dated 8/13/18 revealed the resident required physical assistance with eating and had cognitive impairment. Review of the negotiated service agreement	{S5185}		

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{S5185}	Continued From page 3	{S5185}		

dated 8/13/18 revealed staff assisted the resident with meals and the resident received a mechanical soft to full liquid diet.

Review of the residents service plan dated 5/31/18 revealed he/she received a regular diet.

Review of the physicians progress note dated 10/17/17 revealed the resident was to receive a regulate diet.

Review of the medical record lacked a medical providers order for mechanical soft to full liquid diet.

Observation on 10/25/18 at 10:53 AM certified staff A served the resident a grilled ham and cheese sandwich. Observation revealed the resident was able to eat the sandwich without difficulties.

During an interview on 10/25/18 at 10:53 AM certified staff A reported the resident would sometimes not eat and ate better if we provided him/her soft foods. Staff A reported the resident did not have any kind of food restrictions he could just eat the softer foods better.

During an interview on 10/25/18 at 10:55 AM administrative staff B reported he/she did not know why the negotiated service agreement would say the resident received a mechanical soft diet to full liquid diet and the physicians progress not said he/she received a regular diet. Staff B looked through multiple paperwork and could not find physicians orders for a mechanical soft diet or directions from a medical provider or dietitian on how to prepare a mechanical soft diet.

- Review of resident #80's record revealed he/she

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{S5185}	Continued From page 4 admitted to the facility on 5/17/17 with diagnosis of type II diabetes mellitus and ischemic cardiomyopathy. Review of the functional capacity screen dated 8/10/18 revealed the resident required supervision with ADLs, including eating. Review of the negotiated service agreement dated 8/19/18 revealed the resident received a low concentrated sweet diet and could have deserts. Review of the residents record lacked an order for limited concentrated sweet diet. Observation on 10/25/18 at 9:10 AM the resident came into the dining room and sat down for breakfast. Staff served the resident a glass of orange juice, a banana, and bowl of frosted mini-wheats. During an interview on 10/25/18 at 10:15 AM stated there were no residents that received a therapeutic diet and he/she went off the menu. During an interview on 10/25/18 at 10:55 AM administrative staff B reported he/she could not find record of a medical providers direction on how to prepare the resident's therapeutic diet. The operator failed to provide dietary services to 2 (#50, #80) of 3 residents as identified in their negotiated service agreement and failed to ensure a medical care providers order for therapeutic diet and instructions on how to prepare the therapeutic diet.	{S5185}		