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SEDGWICK PLAZA	2455 N WOODLAWN STREET WICHITA, KS 67220

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey of the above assisted living facility on 6/18/18, 6/19/18, 6/20/18, and 6/21/18.	S 000		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility 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 26-41-204(a) The facility reported a census of 28 residents. The sample included 3 residents and 1 focus review resident. Based on record review, observation, and interview for 2 (#203 and #201) of 3 residents sampled, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care service that met the needs of each resident related to the use of bed mobility devices. Findings included: - Record review for resident #203 revealed an admission date of 4/13/17 with diagnoses of chronic atrial fibrillation and bladder cancer.	S3155		

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

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S3155	Continued From page 1 Functional capacity screen dated 5/17/18 indicated resident required supervision with toileting and mobility; was independent with transferring; experienced impaired short-term memory, memory recall, and decision making; was at risk for falls; and required use of a walker for mobility. Negotiated service agreement dated 5/17/18 contained a check-mark to indicate resident required assistance with transferring and mobility. Health care service plan dated 5/17/18 documented staff to provide stand-by assistance for ambulation with walker and wheelchair for longer distances. The health care service plan did not document resident's need for bed mobility device. At 10:47 a.m. on 6/19/18, surveyor observed resident in his/her apartment. Resident was in bed with head of bed elevated and a half side rail up on each side of bed. During an interview with resident, surveyor asked resident about his/her use of side rails and resident unable to state how he/she used the rails for mobility. The resident's record lacked an assessment of the safety of the side rails and the negotiated service agreement/health care service plan lacked a description of resident's need for and use of the side rails. During an interview at 11:05 a.m. on 6/19/18, licensed nurse C stated resident used the side rails when being repositioned in bed and when sitting on edge of bed. Licensed nurse C stated he/she had not assessed the safety of the side rails and resident's ability to safely and appropriately use the side rails for bed mobility.	S3155		

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S3155	Continued From page 2 Licensed nurse C confirmed the resident's negotiated service agreement/health care service plan lacked a description of resident's use of side rails. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care service that met the needs of resident #203 related to the use of bed mobility devices. - The resident roster documented resident #201 had side rails on his/her bed. Record review for resident #201 revealed an admission date of 11/2/15 with diagnoses of hypertension, anemia, and depression. Functional capacity screen dated 10/25/17 indicated resident was independent with transferring; required supervision with ambulation with a walker; and experienced impaired short-term memory and memory recall. Negotiated service agreement and health care service plan dated 10/25/17 lacked description of services for the use of side rails on bed. Record lacked an assessment of the safety of the side rails and resident's ability to safely and appropriately use the side rails. At 12:16 p.m. on 6/19/18, licensed nurse C provided an assessment dated 6/14/17 that resident able to demonstrate use of side rail; side rail bolted to bed; and a 2.25 inch space between mattress and side rail. Licensed nurse C stated resident's negotiated service agreement and health care service plan lacked a description of resident need for and use of side rails.	S3155		

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S3155	Continued From page 3 During an interview with resident at 1:30 p.m. on 6/19/18, surveyor observed a side rail on each side of the head of the bed and a trapeze above the bed. Resident stated he/she used the rails to keep from falling out of bed but could not state how he/she used the trapeze. The record lacked an assessment of the safety of the trapeze and resident's ability to safely and appropriately use the trapeze. Negotiated service agreement and health care service plan lacked a description of resident's need for and use of a trapeze. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care service that met the needs of resident #201 related to the use of bed mobility devices.	S3155		
S3166 SS=D	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(e) The facility reported a census of 28 residents. The sample included 3 residents and 1 focus	S3166		

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S3166	Continued From page 4	S3166		

review resident. Based on record review and interview for 1 (certified staff F) of 1 certified medication aide file reviewed and 1 (#202) of 1 sampled resident requiring glucometer testing of blood sugar levels, the licensed nurse failed to delegate the procedure to the employee as specified under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.

Findings included:

- Review of 1 certified medication aide employee file hired 5/5/4/18 revealed the lack of documentation that a licensed nurse delegated the procedure of use of a glucometer to test a resident's blood sugar.

Record review for resident #202 revealed an admission date of 6/7/18 with diagnoses of diabetes mellitus type 2, macular degeneration, and hypertension. Resident's functional capacity screen dated 6/7/18 indicated resident was unable to perform management of medications and medical treatments. The health care service plan dated 6/6/18 documented staff to perform blood sugar testing for resident with a glucometer at bedtime and as needed.

During an interview at 1:15 p.m. on 6/19/18, resident #202 stated he/she wore a Dexcom device that continuously monitored his/her blood sugar but he/she received glucometer testing also due to unstable blood sugar.

At 2:55 p.m. on 6/19/18, licensed nurse C stated he/she did not demonstrate use of a glucometer and did not observe certified staff F perform the procedure.

The licensed nurse failed to delegate glucometer

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S3166	Continued From page 5 testing to certified staff F specified under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S3166		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility 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 facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 28 residents. The sample included 3 residents and 1 focus review resident. Based on record review, interview, and observation for 1 (#204) of 1 focus review resident, the operator failed to ensure that all medications and biologicals were administered to the resident in accordance with a medical care provider's written order, professional standards of	S3200		

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S3200	Continued From page 6 practice, and manufacturer's recommendation. Based on record review and interview for 1 (#202) of 3 residents sampled, the operator failed to ensure that all medications and biologicals were administered to the resident in accordance with a medical care provider's written order Findings included: - Record review for resident #204 revealed an admission date of 2/22/03 with diagnosis of insulin dependent diabetes mellitus. Functional capacity screen dated 10/26/17 indicated resident required physical assistance management of medications. Negotiated service agreement dated 10/26/17 documented facility management of medications. Health care service plan dated 10/26/17 documented licensed nurse or certified medication aide administered medications to resident and resident self-injected insulin and obtained own blood sugar readings with glucometer. At 3:30 p.m. on 6/18/18, certified staff J opened the top drawer of the medication cart. Surveyor observed a Levemir insulin pen that lacked a resident's name and a date the pen was opened and a Novolog insulin pen with the name of resident #204 but no date the pen was opened. Certified staff J stated each pen belonged to (resident #204). Note: Manufacturer of Levemir documents the insulin expires 42 days after the pen is opened. Manufacturer of Novolog documents the insulin	S3200		

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S3200	Continued From page 7 expires 28 days after pen is opened. At 11:55 a.m. on 6/19/18, licensed nurse C stated staff were instructed to label insulin pen with the date opened. Review of medical care provider's written orders revealed resident self-injected insulin subcutaneously of Levemir 15 units at bedtime and Novolog 17 units at breakfast, 12 units at lunch, and 30 units at dinner. At 10:02 a.m. on 6/19/18, licensed nurse C stated resident did not receive Levemir insulin at bedtime on 6/16/18 and 6/17/18 because Levemir did not show up at that time on the electronic medication administration record. Licensed nurse C did not know why this happened but the staff member administering medications on 6/18/18 discovered this and notified nurse and was instructed to take Levemir pen to resident to self-inject. The operator failed to ensure that all medications and biologicals were administered to resident #204 in accordance with a medical care provider's written order, professional standards of practice, and manufacturer's recommendation. - Record review for resident #202 revealed an admission date of 6/7/18 with diagnoses of diabetes mellitus type 2 and macular degeneration. Functional capacity screen dated 6/7/18 indicated resident was unable to perform medication management. Negotiated service agreement dated 6/7/18 documented facility management of medications.	S3200		

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S3200	Continued From page 8 Health care service plan dated 6/6/18 documented licensed nurse or certified medication aide administered medications to resident as ordered by physician. Comparison of the written physician orders with the June 2018 medication administration record (MAR) revealed an order for Occuvite/Lutein (for eye health) 1 capsule daily by mouth signed by medical care provider on 6/1/18 but not entered on the MAR. During an interview at 12:52 p.m. on 6/19/18, licensed nurse C confirmed resident to receive Occuvite/Lutein and not listed on MAR. Licensed nurse C stated resident not receiving the medication if not listed on the MAR. The operator failed to ensure that all medications and biologicals were administered to resident #202 in accordance with a medical care provider's written order.	S3200		
S3211 SS=F	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and	S3211		

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S3211	Continued From page 9 the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(3) The facility reported a census of 28 residents. The sample included 3 residents and 1 focus review resident. Based on record review, interview, and observation for all residents receiving facility management of medications, the operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on each over-the-counter (OTC) medication package or container. Findings included: - Review of the resident roster revealed the facility provided medication management for 24 residents. At 3:32 p.m. on 6/18/18 certified staff J opened the drawers of the medication cart. Surveyor observed numerous bottles of OTC medications in the drawers that did not contain the full name of the resident. Some of the OTC medications as follows: Bottles or packages without a resident's name: Glucosamine/chondroitin (supplement) Multivitamins (supplement) Lutein/zeaxanthin eye health) Calcium with D (supplement) Loratadine tablets (antihistamine) Metamucil powder (laxative)	S3211		

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S3211	Continued From page 10 Cranberry tablets (supplement) Bottles or packages with a resident's first name and/or apartment number: Multivitamins (supplement) Iron sulfate (supplement) B-12 (supplement) Lutein/zeaxanthin (eye health) Aspirin 81 milligrams (heart health) Naproxen sodium (pain relief) Acetaminophen 4 bottles (pain relief) Dulcolax tablets (laxative) Vitamin D (supplement) Vitamin C (supplement) At this same time certified staff J stated whoever was passing medications and received the OTC bottle or package from resident or resident's family member, labeled, and placed in medication cart. Certified J stated try to label with resident's apartment number. During an interview at 12:49 p.m. on 6/19/18, operator B stated the facility did not have a policy for labeling OTC medications brought in to the facility for staff to administer to residents. For all residents receiving facility management of medications, the operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on each OTC medication package or container.	S3211		
S3248 SS=E	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following	S3248		

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S3248	Continued From page 11 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. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(2)(3) The facility reported a census of 28 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1 (certified staff F) of 4 certified staff files reviewed, the business office manager failed to request a background check from the department, pursuant to K.S.A. 39-970 and amendments thereto. Based on record review and interview for 4	S3248		

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S3248	Continued From page 12	S3248		

(certified staff D, certified staff E, certified staff F, and certified staff G) of 4 certified employee files reviewed, the business office manager failed to ensure each one of the employee files contained supporting documentation, dated prior to or on date hired, from the Kansas nurse aide registry (KNAR) 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 the employee file for certified staff F revealed a hire date of 5/4/18. The file lacked documentation of a criminal background check requested from the department.

At 2:41 p.m. on 6/19/18, business office manager H stated a criminal background check was not requested for the employee.

For certified employee F, the business office manager failed to request a background check from the department, pursuant to K.S.A. 39-970 and amendments thereto.

- Review of 4 certified employee files to determine that each file contained supporting documentation, obtained prior to employees providing resident care, that the employee did not have a finding of having abused, neglected, or exploited a resident in an adult care home revealed the following:

The file of certified staff D hired 3/13/18 contained a KNAR form without a date to indicate when the check was performed.

The file of certified staff E hired 8/9/17 contained a KNAR form dated the check was completed on

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S3248	Continued From page 13 8/17/17. The file of certified staff F hired 5/4/18 lacked proof that KNAR check was completed. The file of certified staff G hired 11/17/16 contained a KNAR form without a date to indicate when the check was performed. At 2:41 p.m. on 6/19/18, business office manager H stated he/she did not check with the Kansas nurse aide registry prior to hiring certified staff F and unable to determine if a KNAR check was performed for the other 3 employees prior to providing resident care. Business office manager failed to request a criminal background check from the department for one certified employee and failed to provide evidence for four certified employees that the KNAR was contacted prior to or on date hired, to determine that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home.	S3248		