STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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 the resurvey with complaint #119334 at the above named facility on 4/4/18, 4/5/18, 4/9/18, 4/10/18, 4/11/18 and 4/12/18. Revised 2567 sent to facility on 5/1/2018	S 000		
S5080 SS=D	26-42-201 (a) (b) Functional Capacity Screen on Admission (a) On or before each individual ' s admission to a home plus, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the home, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-42-201 (b) The facility census totaled 7 residents with 3 included in the sample and 2 for a focused review. Based on interview and record review licensed nurse C/Operator failed assess 1 of 5 residents (#702) whose functional capacity screening indicated the need for health care	S5080		

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
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5080	Continued From page 1 services. Findings included: - Record review on 4/4/18 at 2:40 PM for resident #702 revealed an admission date of 12/27/17 with diagnoses of hypertension, atrial fibrillation, type 2 diabetes, hypothyroidism and pneumonia. Review of the admission Functional Capacity Screen (FCS) date 12/27/17 revealed the resident required physical assistance for bathing, dressing, toileting, transfers, walking/mobility, he/she unable to perform medication management/treatments and was at risk for falls. Certified medication aide A signed the FCS on 12/28/17 without a signature of a nurse to indicate the resident was screened by a nurse. Interview on 4/5/18 at 3:45 PM with licensed nurse C/Operator confirmed the FCS lacked a signature by a licensed nurse to indicate the FCS was completed by a licensed nurse. Licensed nurse C/Operator failed to assess resident #702 whose functional capacity screening indicated the need for health care services	S5080		
S5105 SS=D	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5105	Continued From page 2 agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1)(2)(3) The facility reported a census of 7 residents. The sample included 3 residents and 2 focused reviews for safety. Based on record review and interview for 1 of 3 residents sampled (#702), the Operator failed to ensure the resident's negotiated service agreement contained the description of services the resident would receive, identification of the provider of each service and the party responsible for payment of the services. Findings included: - Record review on 4/4/18 at 2:40 PM for resident #702 revealed an admission date of 12/27/17 with diagnoses of hypertension, pneumonia, atrial fibrillation, type 2 diabetes and hypothyroidism. Review of the admission Functional Capacity Screen (FCS) date 12/27/17 revealed the resident required physical assistance for bathing, dressing, toileting, transfers, walking/mobility1and was at risk for falls.	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5105	Continued From page 3 The resident's physician on 12/24/17 ordered to admit the resident to the facility, continue current medications and treatments. The current orders included Physical Therapy (PT) and Occupational Therapy (OT) for 4 weeks with a start date of 12/14/17. The Negotiated Service Agreement (NSA) dated 12/27/17 included the name of an outside provider for PT services but did not identify the source of the OT services. The NSA lacked the party responsible for payment of the services. Review of the nursing notes between 12/27/17 and 1/11/18 revealed no information regarding the resident abilities with activities of daily living or that he/she received outside skilled services of PT/OT. Observation on 4/5/18 at 2:36 PM revealed OT staff J assisted the resident with ambulation. He/she reported the resident also received PT services. During an interview on 4/5/18 at 3:45 PM licensed nurse C/Operator confirmed the NSA lacked information about OT and the party responsible for payment of the skilled services of PT and OT for the resident. Licensed nurse C/Operator failed to ensure the NSA for resident #702 included the name of the provider for the OT services and the party responsible for payment of outside services.	S5105		
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	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5155	Continued From page 4 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 7 residents. The sample included 3 residents and 2 focused reviews for safety. Based on observation, interview and record review for 5 of 5 residents sampled (#701, #702, #703, #704 and #705) licensed nurse C/Operator failed to provide or coordinate the provision of necessary health care services which met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #701 on 4/4/18 revealed an admission date of 6/20/17 with diagnoses of acute respiratory failure, aspiration, history of aftercare following joint replacement and cystitis. The admission Functional Capacity Screen dated 6/20/17 indicated the resident required physical assistance with bathing, dressing, toileting, transfers, walk/mobility and continent of urinary bladder. He/she had impaired decision making with intact memory.	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5155	Continued From page 5 The admission nursing note dated 6/20/17 at 8:40 PM included the resident had a Foley catheter (a tube inserted into the urinary bladder to drain urine) upon arrival. The Negotiated Service Agreement dated 6/20/17 indicated the resident had an indwelling catheter, required assistance of 2 staff to toilet and catheter needs but failed to include specific care needs related to use of an indwelling urinary catheter such as need for removal and reinsertion. The Health Services care plan dated 6/20/17 directed staff to assist the resident with 2 staff for toileting, had an indwelling catheter and take to the toilet when needed. The HSCP did not include specific care needs of an indwelling catheter such as handling, cleaning, removal or reinsertion. Review of the admission physician orders revealed no order for the urinary catheter. A telephone order dated 8/22/17 directed staff to insert an indwelling Foley catheter with bag - "STAT" (immediately) size 16 French. On 8/31/17 the physician ordered indwelling Foley catheter (3 piece) 16 French. The June 2017 medication administration record (MAR) revealed staff monitored the resident for urinary catheter output with no information related to catheter changes. The July 2017 MAR included catheter 16 French with 30 cubic centimeter (cc)balloon - reinsert Foley catheter as directed dated 6/30/17. On 7/20/17 staff added to the July 2017 MAR to flush Foley catheter with	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5155	Continued From page 6	S5155		

200 cc daily for 10 days. The MAR included initials to indicate treatment was performed on all days except 7/27/18 and 7/28/18. The August, September 2017, October and November 2017 MAR included catheter 16 French with 30 cc balloon - reinsert as directed (6/30/17).

The December 2017 MAR included catheter change every 30 days without a start date but initialed as completed on 12/29/17. The January 2018 MAR included change catheter every 30 days dated 1/9/18 and initialed as completed on 1/30/18. The February 2018 MAR included the same order for catheter change but no initials to indicate the catheter was changed. The March 2018 MAR included the same order with initials of change on 3/1/18 and 3/24/18.

Review of the nursing notes revealed no information related to catheter changes or handling.

Review of the laboratory results in the resident's record revealed staff obtained a urine specimen on the following days: 7/15/17, 8/1/17, 9/1/17, 9/24/17, 10/16/17, 11/8/17, 11/27/17, 3/2/18 and 3/25/18.

Observation on 4/4/18 at 9:00 AM revealed direct care staff F and direct care staff G assisted the resident to transfer from the wheelchair to the recliner in the living room. Staff initially left the catheter bag attached to the wheelchair base, then paused the transfer to move the bag and placed the bag directly on the floor.

Interview on 4/5/18 at 11:30 AM with certified medication aide A revealed staff changed the resident's urinary catheter every time the staff obtained a urine sample.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5155	Continued From page 7 Interview on 4/5/18 at 12:05 PM with licensed nurse C/Operator revealed the resident had the indwelling catheter since admission for neurogenic bladder. He/she confirmed the record lacked physician orders regarding how often to change the indwelling catheter. He/she added to change it monthly as a standard of nursing practice. He/she said the catheter was changed every time the staff obtained a urinary specimen for testing to ensure it was a clean specimen. He/she confirmed the NSA/HSCP did not include information about urinary catheter changes or catheter flushes or who had the responsibility to perform these special care needs. Licensed nurse C/Operator failed to provide or coordinate the provision of necessary health care services which met the needs of resident #701 in regards to catheter handling, changes and flushes. - Record review for resident #702 revealed an admission date of 12/27/17 with diagnoses of hypertension, pneumonia, atrial fibrillation, type 2 diabetes and hypothyroidism. Review of the admission Functional Capacity Screen (FCS) date 12/27/17 revealed the resident required physical assistance for bathing, dressing, toileting, transfers, walking/mobility and was at risk for falls. The Amended Health Service Plan dated 1/11/18 included resident wants one half rail so that he/she knows to get out of the bed on the other side. Rail is not used as a restraint. The record lacked an assessment to verify the rail was not a restraint, the resident used the rail	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5155	Continued From page 8	S5155		

safely and the rail design/attachment/gaps and mechanisms were safe.

Observation on 4/4/18 at 10:15 AM revealed the resident had a half side rail attached to the bed on one side. The resident was seated in a recliner in the living room at the time.

During an interview on 4/9/18 at 3:20 PM with licensed nurse C/Operator confirmed he/she had not completed a side rail assessment which included the above specifics.

Licensed nurse C/Operator failed to provide or coordinate the provision of necessary health care services which met the needs of resident #702 related to side rail use and were in accordance with the functional capacity screening and the negotiated service agreement.

- Record review for resident #703 revealed an admission date of 6/14/13 with diagnoses of pneumonia and dementia.

The annual Functional Capacity Screen dated 7/4/17 indicated the resident needed supervision with transfers, walking and had behavior of wandering.

The Negotiated Service Agreement (NSA) dated 7/4/17 included the resident could ambulate independently with supervision. The NSA included behavioral directions of RN will be responsible for management of all behavioral issues of resident. The NSA did not include interventions related to wandering behavior. Under the toileting portion revealed toileting required 2 staff because the resident may be combative. Under the additional services not listed revealed staff must supervise to ensure the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5155	Continued From page 9	S5155		

resident does not toilet in areas other than the toilet, the resident would remain appropriately dress to maintain dignity with no additional information related to wandering behavior.

The Health Services Care Plan dated 7/4/17 included resident could ambulate with supervision of 1 staff who would encourage the resident to use a walker for safety. Under behavior it included RN would report any inappropriate behavior to physician and report plan of action to power of attorney. Under personal information it included resident had Alzheimer's and will react to any "Negative" talk, negatively. Positive re-enforcement or distraction works better for resident. Supervise resident closely for his/her habit of toileting in trash cans, chairs etc. In addition, monitor resident for removing his/her clothing in public areas.

Observation on 4/4/18 during the initial tour which began at 9:08 AM revealed the facility had locking safety gates to control the wandering resident from entry into other resident rooms, bathrooms and kitchen area.

Observation on 4/4/18 at 1:50 PM revealed the resident independently ambulated without a walker in the formal dining room unsupervised. At 1:55 PM certified medication aide A approached the resident and guided him/her back to the living room.

Observation on 4/5/18 at 2:00 PM revealed the resident independently ambulated without a walker from the living room towards the dining room and attempted to open the safety gait to enter the kitchen.

During interview on 4/4/18 at 9:40 AM licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5155	Continued From page 10	S5155		

nurse C/Operator identified the resident with wandering behavior.

During interview on 4/9/18 at 3:20 PM with licensed nurse C/Operator confirmed the NSA/HSCP lacked provision related to care and management of the resident's wandering behavior.

Licensed nurse C/Operator failed to provide or coordinate the provision of necessary health care services which met the needs of resident #703 with wandering behavior and were in accordance with the functional capacity screening and the negotiated service agreement.

- Record review for resident #704 revealed an admission date of 2/11/11 with diagnoses of stroke and hypertension.

The annual Functional Capacity Screen dated 3/5/18 indicated the resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility and eating. He/she had impaired cognition.

The Negotiated Service Agreement dated 3/5/18 included the resident needed assistance of 1 staff for transfers. He/she preferred not to use a gait belt and staff were trained to safely transfer without gait bed and not to grab the resident under the shoulders/armpits. The resident needed assistance of 1 staff to move with assist of a wheelchair. Under additional services not listed ...resident used half rails to move him/herself - not as a restraint.

The Health Services care plan dated 3/5/18 identified the resident was not able to self-transfer and needed assistance of 1 staff. The plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5155	Continued From page 11	S5155		

indicated the resident needed assistance of 1 staff for dressing and toileting. The plan did not include information related to side rail usage.

The record lacked an assessment to verify the rail was not a restraint, the resident used the rail safely and the rail design/attachment/gaps and mechanisms were safe.

Observation on 4/4/18 10:05 AM revealed half rails on both sides of the resident's bed in the upright position.

During an interview on 4/9/18 at 3:20 PM with licensed nurse C/Operator confirmed he/she had not completed a side rail assessment which included the above specifics.

Licensed nurse C/Operator failed to provide or coordinate the provision of necessary health care services which met the needs of resident #702 related to side rail use and were in accordance with the functional capacity screening and the negotiated service agreement.

- Record review for resident #705 revealed an admission date of 5/3/17 with diagnoses of left humerus non-displaced fracture on 6/24/17, fracture of left hip 4/19/17, osteoporosis, dementia and dysphagia.

The admission Functional Capacity Screen dated 5/3/17 indicated the resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility and eating. He/she had impaired cognition, communication and was at risk for falls/unsteadiness.

The Amended Negotiated Service Agreement dated 1/12/18 identified the resident used half

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5155	Continued From page 12 rails to help get in/out of bed. He/she could hold rails during turning. Rails are not used as a restraint. The record lacked an assessment to verify the rail was not a restraint, the resident used the rail safely and the rail design/attachment/gaps and mechanisms were safe. Observation on 4/5/18 at 10:15 AM revealed the resident's bed had a half side rail attached During an interview on 4/9/18 at 3:20 PM with licensed nurse C/Operator confirmed he/she had not completed a side rail assessment which included the above specifics. Licensed nurse C/Operator failed to provide or coordinate the provision of necessary health care services which met the needs of resident #705 related to side rail use and were in accordance with the functional capacity screening and the negotiated service agreement.	S5155		
S5165 SS=E	26-42-204 (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 26-42-204(e) The facility reported a census of 7 residents with	S5165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5165	Continued From page 13	S5165		

3 sampled and 2 focused reviews. Based on interview and record review licensed nurse C/Operator failed to ensure nursing duties were delegated to unlicensed staff who had received training on the procedures and could perform the duty with reasonable skill and safety for resident #701 regarding catheter insertion and flushing.

Findings included:

- Record review for resident #701 on 4/4/18 revealed an admission date of 6/20/17 with diagnoses of acute respiratory failure, aspiration, history of aftercare following joint replacement and cystitis.

The admission Functional Capacity Screen dated 6/20/17 indicated the resident required physical assistance with bathing, dressing, toileting, transfers, walk/mobility and continent of urinary bladder. He/she had impaired decision making with intact memory.

The admission nursing note dated 6/20/17 at 8:40 PM included the resident had a Foley catheter (a tube inserted into the urinary bladder to drain urine) upon arrival.

The Negotiated Service Agreement dated 6/20/17 indicated the resident had an indwelling catheter, required assistance of 2 staff to toilet and catheter needs.

The Health Services care plan dated 6/20/17 indicated the resident had an indwelling catheter.

Review of the July 2017 medication/treatment administration record (MAR/TAR) revealed directions to staff to flush the Foley catheter with 200 cubic centimeters daily for 10 days. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5165	Continued From page 14	S5165		

record included 4 initials of a nurse, and 5 initials of certified medicaiton aide (CMA) staff as follows: 7/22/17, 7/23/17 and 7/25/17 initials of CMA G, 7/28/17 initials of CMA E and 7/29/17 initials of CMA K.

The December 2017 MAR/TAR included catheter change every 30 days without a start date but initialed as completed on 12/29/17 by CMA G.
The January 2018 MAR included change catheter every 30 days dated 1/9/18 and initialed as completed on 1/30/18 by CMA D.
The March 2018 MAR included the same order with initials of change on 3/1/18 and 3/24/18 by CMA G.

Review of the nursing notes revealed no information related to catheter changes or the flushes.

Interview on 4/5/18 at 11:30 AM with certified medication aide A revealed staff changed the resident's urinary catheter every time the staff obtained a urine sample. He/she stated the CMAs do the catheter removal and reinsertion.

Review of the laboratory results in the resident's record revealed staff obtained a urine specimen on the following days: 7/15/17, 8/1/17, 9/1/17, 9/24/17, 10/16/17, 11/8/17, 11/27/17, 3/2/18 and 3/25/18.

Interview on 4/5/18 at 12:05 PM with licensed nurse C/Operator revealed the resident had the indwelling catheter since admission for neurogenic bladder. He/she said the catheter was changed every time the staff obtained a urinary specimen for testing to ensure it was a clean specimen. He/she confirmed delegating the duty of catheter removal/reinsertion and catheter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5165	Continued From page 15 flushes to the CMAs. Review of the personnel records for CMAs D, E, and G revealed no evidence of training for the nursing duty of catheter flushin, catheter removal and reinsertion. Interview on 4/5/18 at 2:00 PM with licensed nurse C/Operator confirmed the personnel records lacked evidence of training and performance of skills safely for duties delegated to the CMAs in regard to catheter flushes and catheter removal/insertion. The Kansas Nurse Practice Act - K.S.A. 65-1124 (m) performance of a nursing procedure by a person when that procedure is delegated by a licensed nurse, within the reasonable exercise of independent nursing judgment and is performed with reasonable skill and safety by that person under the supervision of a registered professional nurse or a licensed practical nurse; Licensed nurse C/Operator failed to ensure nursing duties were delegated to unlicensed staff who had received training on the procedures, could perform the duty with reasonable skill and safety for resident #701 regarding catheter insertion and flushing.	S5165		
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:	S5171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5171	Continued From page 16 KAR 26-42-204(i) The facility reported a census of 7 residents. The sample included 3 residents and 2 with a focused review. Based on interview and record review licensed nurse C/Operator failed to ensure health care services were provided to 3 of 5 residents (#701, #702 and #705) by qualified staff in accordance with acceptable standards of practice regarding making changes to the Health Service Plan by a non-licensed staff. Findings included: - Record review for resident #701 on 4/4/18 revealed an admission date of 6/20/17 with diagnoses of acute respiratory failure, aspiration, history of aftercare following joint replacement and cystitis. The admission Functional Capacity Screen dated 6/20/17 indicated the resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility and eating. He/she had impaired decision making with intact memory. The Negotiated Service Agreement (NSA) 6/20/17 directed staff to provide assist of 2 staff for bathing and hair washing, dressing/undressing, toileting needs and transfers. The NSA included fall monitoring and identified the resident as at risk. The Health Services Care Plan dated 6/20/17 directed staff to assist the resident with ambulation with 1 staff, needed 2 staff assist with transfers, dressing, bathing and toileting. The resident's record had 4 Amended Health	S5171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5171	Continued From page 17 Service Plan as follows 10/30/17 outside provider - resident would be seen by a podiatrist for foot (nail) care as needed and signed by certified medication aide (CMA) A and not a nurse. 1/20/18 resident is assist of 1 with bathing, dressing/undressing, toileting and transferring on 10/13/17. Resident ambulates with walker and assist of 1. The amended health service plan was signed by CMA A and not a nurse. 1/20/18 physical therapy (PT) from (named) home health discontinued on 10/13/17 uses walker with 1 person assist and signed by CMA A and not a nurse. 3/14/18 resident's diet was changed from regular to mechanical soft diet and nectar thickened liquids on 3/8/18 and signed by CMA A and not a nurse Observation on 4/4/18 at 9:11 AM revealed certified medication aide (CMA) G and direct care staff F used a gait belt and assisted the resident to stand from the wheelchair and transfer to a recliner in the living room. Observation on 4/4/18 at 12:40 PM revealed staff served the resident a regular diet with nectar thick liquids and he/she ate independently. Observation on 4/5/18 at 11:25 AM CMA E and A used a gait belt to assist the resident to stand and transfer from a recliner in the living room to take a few steps then sit in a wheelchair. At 11:31 AM CMA E and A assisted the resident to transfer from the wheelchair to the toilet. During an interview on 4/4/18 at 3:00 PM with licensed nurse C/Operator confirmed the Amended Health Service Plans (4) were signed by the CMA and not a nurse.	S5171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5171	Continued From page 18 Licensed nurse C/Operator failed to ensure health care services were provided to this resident by qualified staff in accordance with acceptable standards of practice regarding making changes to the Health Service Plan by a non-licensed staff. - Record review for resident #702 revealed an admission date of 12/27/17 with diagnoses of hypertension, atrial fibrillation, type 2 diabetes, hypothyroidism and pneumonia. Review of the admission Functional Capacity Screen (FCS) date 12/27/17 revealed the resident required physical assistance for bathing, dressing, toileting, transfers, walking/mobility, he/she unable to perform medication management/treatments and was at risk for falls. The Negotiated Service Agreement (NSA) dated 12/27/17 indicated the resident required 1 staff assistance with bathing/hair washing, dressing, toileting, transfers and ambulated with 1 staff assist and a walker. The NSA included fall monitoring and identified the resident as at risk. Under additional services not listed included staff would encourage resident to comply with all physical therapy instructions. The Health Service Care Plan dated 12/27/17 identified the resident needed staff assist of 1 for transfers, dressing, hygiene/grooming, bathing and toileting. Under personal information - resident had a fall resulting in left fractured hip prior to coming to the facility. The Amended Health Service Plan (AHSP) dated 1/11/18 - resident wants one half rail so that he/she knew to get out of bed on the other side.	S5171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5171	Continued From page 19 Rail is not used as a restraint. The AHSP was signed by certified medication aide A and not a nurse. Observation on 4/4/18 at 10:15 AM revealed the resident had a half side rail attached to the bed on one side. The resident was seated in a recliner in the living room at the time. During an interview on 4/4/18 at 3:00 PM with licensed nurse C/Operator confirmed the Amended Health Service Plan was signed by the CMA and not a nurse. Licensed nurse C/Operator failed to ensure health care services were provided to this resident by qualified staff in accordance with acceptable standards of practice regarding making changes to the Health Service Plan by a non-licensed staff. - Review of the record for resident #705 revealed the resident admitted to the facility on 5/3/17 with diagnoses of fractured left hip status post fall at home, osteoporosis, dementia and dysphagia. The admission Functional Capacity Screen dated 5/3/17 indicated the resident required physical assistance for bathing, dressing, toileting, transfers and walking/mobility. The resident had impaired cognition with short-term and long-term memory, memory/recall and decision-making. He/she was at risk for falls or unsteadiness. The Negotiated Service Agreement (NSA) dated 5/3/17 identified the resident as a fall risk and directed the nurse to monitor for fall risks and place intervention in place when necessary. The NSA directed staff to provide assistance of 1 staff	S5171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5171	Continued From page 20	S5171		

for bathing, dressing/undressing, toileting, transfers and walking with a walker.

The Health Care Services Care Plan (HCSCP) dated 5/3/17 indicated the resident needed staff assistance of 1 to ambulate with the use of a walker and gait belt. The resident was unable to self-transfer and needed 1 staff assistance and gait belt. He/she also needed assistance of 1 staff for toileting needs. The HCSCP identified the resident as a fall risk and directed staff to keep the resident's door open in order to monitor the resident and prevent falls. Staff updated the care plan with 6/23/17 marker board with no directions of it's use or how this will prevent further falls. On 6/24/17 staff updated the care plan with bed-chair alarms.

The Amended Health Service Plan (AHSP) dated 10/30/17 identified the resident would be seen by a podiatrist for foot (nail) care as needed and signed by certified medication aide (CMA) A and not a nurse.

The AHSP dated 1/11/18 included - resident uses (1) half rails to help get in/out of bed and to help hold when turning. Rails are not used as a restraint. The AHSP was signed by certified medication aide A and not a nurse.

Observation on 4/5/18 at 10:15 AM revealed the resident's bed had a half side rail attached.

Interview on 4/5/18 at 10:15 AM with CMA E revealed the resident was no longer able to use the side rail.

During an interview on 4/4/18 at 3:00 PM with licensed nurse C/Operator confirmed the Amended Health Service Plan was signed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5171	Continued From page 21 CMA and not a nurse. Licensed nurse C/Operator failed to ensure health care services were provided to this resident by qualified staff in accordance with acceptable standards of practice regarding making changes to the Health Service Plan by a non-licensed staff.	S5171		
S5185 SS=D	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 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 (c) The facility reported a census of 7 residents. The sample included 1 resident with orders for a mechanically altered diet. Based on observation, interview and record review licensed nurse C/Operator failed to provide resident #701 with a mechanically altered diet as ordered by the	S5185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5185	Continued From page 22	S5185		

resident's physician in the resident's clinical record.

Findings included:

- Record review for resident #701 on 4/4/18 revealed an admission date of 6/20/17 with diagnoses of acute respiratory failure, aspiration, history of aftercare following joint replacement and cystitis.

The admission Functional Capacity Screen dated 6/20/17 indicated the resident required physical assistance with eating and had impaired decision making with intact memory.

The Negotiated Service Agreement dated 6/20/17 identified the resident needed a regular diet which was provided by the facility and needed physical assistance of staff to ensure resident was brought to all meals.

The Health Services care plan dated 6/20/17 directed staff the resident could feed him/herself a regular diet with thin liquids.

The Amended Health Service Plan dated 3/14/18 indicated the resident's diet was changed from regular to mechanical soft diet and nectar thickened liquids on 3/8/18. There were no further Amended Health Service Plan after 3/8/18 within the resident's record.

The inter-agency transfer from signed on 3/8/18 included a diet order of mechanically altered and nectar thickened liquids.

The speech therapy (ST) evaluation dated 3/27/18 included the resident had a choking episode on bacon which he/she admitted had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5185	Continued From page 23	S5185		

took too big of a bite. He/she was later admitted to the hospital with respiratory failure. During hospital stay he/she was placed on a mechanical soft diet with nectar thick liquids. Resident and family requesting further testing to determine if safe to advance diet back to regular with thin liquids.

The speech swallowing and voice center flexible endoscopic evaluation of swallowing (FEES) dated 3/30/18 indicated the resident demonstrated weak and uncoordinated swallow, nectar thick was safe and efficient. When no using techniques of small sips and chin tuck swallow the resident had episodes of silent aspiration. The speech therapist B indicated he/she felt the resident would be safe with a regular diet with nectar liquids during meals and a candidate for the Frazier Fee Water Protocol (small sips of water using chin tuck after oral care). Speech therapy B made the above recommendations and wrote out a telephone order dated 3/30/18 to change the diet to regular with nectar thick liquids during meals and Frazier Free Water Protocol-thin liquids after oral care with small sips and chin tuck. The Telephone order lacked a signature by a nurse as receiving the order from the physician and the telephone order was not signed by a physician.

Review of the nursing notes between 6/20/17 and 4/5/18 revealed an absence of any notes regarding the choking episodes, the hospitalization, diet order changes or the resident's tolerance of the diet.

Observation on 4/4/18 at 9:11 AM revealed direct care staff F removed a container of clear liquid from the resident and stated the water was not thickened and he/she was to have thickened

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5185	Continued From page 24	S5185		

liquids.

Observation on 4/4/18 at 12:40 PM revealed staff had served the resident a regular diet which included a bowl of stew/soup with approximately 1/2-inch slices of a tubular sausage meat, chunks of potatoes and cabbage. He/she had a small bowl of diced fruit and a glass of red slightly thickened red liquid and a 4-ounce container of ice cream. He/she ate independently and he/she coughed a couple times during the meal but not while actively chewing/swallowing.

During an interview on 4/4/18 at 2:02 PM with direct care staff F revealed the resident had choked on bacon and was admitted to the hospital in March 2018. When he/she returned the diet was mechanical soft with nectar thick liquids. The speech therapist evaluated him/her in the last week or so and he/she can have a regular diet with nectar thick liquids then regular liquids after oral care. Direct care staff F reported earlier that morning he/she removed the resident thin liquid water because the resident had not done the oral care after breakfast yet. He/she confirmed the resident received a regular diet with nectar thick liquids at the noon meal on 4/4/18.

During an interview on 4/4/18 at 3:00 PM with licensed nurse C/Operator confirmed the resident had required a hospital stay after choking. He/she stated the speech therapist changed the diet from mechanical soft to regular. Later after locating the speech therapy documentation and the unsigned telephone order he/she confirmed the order lacked a signature.

On 4/9/18 at 3:20 PM licensed nurse C/Operator stated he/she had sent a text message to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5185	Continued From page 25 resident's physician following the speech therapy visit. He/she confirmed the resident's legal record did not include any documentation of physician notification and/or orders to change the resident's from mechanically soft to regular. Licensed nurse C/Operator failed to provide resident #701 with a mechanically altered diet as ordered by the resident's physician in the resident's clinical record.	S5185		
S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(f) The facility reported a census of 7 residents and had 1 kitchen. Based on observation and interview licensed nurse C/Operator failed to store food items under safe and sanitary conditions regarding dating items when opened to ensure used timely, properly resealing items once opened and labeling as needed. Findings included: - Observation of the kitchen area on 4/4/18 beginning at 9:43 AM revealed the following items	S5195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5195	Continued From page 26 within the free-standing freezer: open package of pre-cooked egg noodles not sealed or dated partially used 1-gallon container of cookies and cream ice cream with no date bag of steak fries opened and not resealed with no date 1.5-quart open container of chocolate frozen yogurt with no date Frozen treat from "Sonic" in an open lidded cup with a spoon in it and no date open 3-pound bag of frozen chicken breast with no date small bag of frozen broccoli no dated and had visible ice crystal formations on the broccoli a 12-ounce package of crinkle cut carrots not sealed and with no date. The dry food area of the kitchen had the following items: open package of shell macaroni not sealed and no date open package of yoke free extra wide noodles no sealed or dated 28-ounce box of white rice open with the tabs of the box in the upright position about 1/2 empty with no date 2-pound partially used box of spaghetti with no date brown sugar 2-pound bag opened and resealed but had no date 16-ounce bag of mini-marshmallows open with no date light brown cracker like food item (resembled graham crackers) in a clear plastic sealed bag not labeled for the food item or dated open 1.5-pound package of country style peppered gravy mix not sealed or dated. a small package of Italian dressing and recipe mix which was torn open, not sealed or dated	S5195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5195	Continued From page 27 a 1.25-ounce package of taco seasoning mix open with edge folded over but not sealed or dated The side by side refrigerator freezer had the following items: Refrigerator open 32-ounce mozzarella shredded cheese with no open date 4-ounce bad of mini pepperoni open not sealed with no date a partially used 8-ounce package of cream cheese not dated open 32-ounce package of shredded mild cheddar cheese with no date a half pound of meat item in a tube (appeared to be ground beef) in a plastic sealed bag with no date and not labeled. Freezer open bag of heat and serve sausage links with no date open container of rainbow sherbet with no date open bag of flour with no date open bag of chopped green peppers with no date During an interview on 4/4/18 at 10:38 AM with licensed nurse C/Operator confirmed the food items were not stored properly. He/she reported knowing the kitchen was a mess and he/she had been working with staff on sealing/labeling/dating of food items when opened. Licensed nurse C/Operator failed to store food items under safe and sanitary conditions regarding dating items when opened to ensure used timely, properly resealing items once opened and labeling as needed.	S5195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5205	Continued From page 28	S5205		
S5205 SS=F	26-42-104 (a) Disaster and Emergency Preparedness 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 reported a census of 7 residents. The sample included 3 residents and 2 residents for focused review on safety. The facility roster identified 3 resident who required a 2-person transfer and 4 residents with cognitive impairment. The facility identified 1 resident with wandering behavior. Based on observation, interview and record review licensed nurse C/Operator failed to ensure the provision of enough staff on duty at all times to safely evacuate the residents to a safe location regarding the 3 residents who required 2 staff to transfer and 1 resident who needed supervision due to wandering behavior. Findings included: - Review of the resident roster completed by licensed nurse C/Operator on 4/4/18 revealed resident #701, #706 and #707 required a 2 person assist to transfer. Residents #703, #704, #705 and #707 had impaired cognition. Resident #703 had wandering behavior. During an interview on 4/5/18 at 3:10 PM licensed nurse C/Operator stated he/she had delegated	S5205		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5205	Continued From page 29	S5205		

the emergency disaster plan training and evacuations to certified medication aide E. He/she stated there were 2 staff on duty at all times. Licensed nurse C/Operator provided documentation for the most recent emergency fire drill with evacuation. The document was a single piece of 8.5 by 11-inch paper. At the top was September 2017 with a line under it and Emergency Plan of Action abuse, neglect, exploitation and infections control. In the top right corner was "Evac fire drill 2:35 PM 2 people 6 minutes with a line and initials of licensed nurse C/Operator. The bottom of the page included signatures of 5 staff and the written first name of 6 residents with no indication what the names signified. The document did not include the specific date of the drill, which staff were part of the drill, how many residents were evacuated and the location of where were the residents evacuated. Licensed nurse C/Operator confirmed the facility had a wandering resident and locked safety gates throughout the facility to keep the resident from wandering into other areas. He/she confirmed 3 residents needed 2-person transfers, 5 of the 7 residents needed a wheelchair to be mobile and 4 of 7 were cognitively impaired. The facility had a fire sprinkler system.

Documentation of emergency fire drills without evacuation dated December 2017 and January 2018 were done in the same format as above. December 2017 right corner "non Evac ...cloud room" initialed by licensed nurse C/Operator with 5 staff signatures and 7 first names of residents. January 2018 right top corner "fire drill non-Evac with staff fire in LR (living room)" no initials or signature of who conducted the drill with 7 staff signatures and 7 first names of residents. Of the 7 residents listed 4 were identified with cognitive impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5205	Continued From page 30 Observation on 4/4/18 at 9:11 AM revealed certified medication aide G and direct care staff F assisted resident #701 to transfer from the recliner in the living room to his/her wheelchair. Observation on 4/4/18 at 11:33 AM revealed certified medication aide A and direct care staff F assisted resident #706 to transfer from the recliner in the living room to a wheelchair. Observation on 4/4/18 at 1:50 PM revealed the resident independently ambulated without a walker in the formal dining room unsupervised. At 1:55 PM certified medication aide A approached the resident and guided him/her back to the living room. Observation on 4/5/18 at 2:00 Pm revealed the resident independently ambulated without a walker from the living room towards the dining room and attempted to open the safety gait to enter the kitchen. Review of the time records for March 2018 and April 1 through April 4, 2018 revealed the facility had 2 staff on duty at all times with 1 staff being a sleeper between 10pm-6am. During an interview on 4/5/18 at 3:10 PM with licensed nurse C/Operator confirmed the notes written in the corner of Emergency Plan of Action, Abuse, Neglect, Exploitation and Infection control that states evacuation fire drill September 2017 lacked the specific date, which staff/residents were involved at what safe location were the residents evacuated to. The December 2017 non-evac drill lacked specific date, time and who was involved documented. The January 2018 also lacked the specific date, time and who was	S5205		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5205	Continued From page 31 involved. Licensed nurse C/Operator failed to ensure the provision of enough staff on duty at all times to safely evacuate the residents to a safe location regarding the 3 residents who required 2 staff to transfer, 5 residents who needed a wheelchair and 1 resident who needed supervision due to wandering behavior.	S5205		
S5230 SS=E	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-207(c) The facility census totaled 7 residents with 3 sampled. Based on record review and interview licensed nurse C/Operator failed to follow tuberculosis (TB) guideline of a two-step testing method for TB which included the date of plantation, date read and the results of the testing	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5230	Continued From page 32 for 2 of 3 sampled residents (#701 and #702). Findings included: - Record review for resident #701 on 4/4/18 revealed an admission date of 6/20/17 with diagnoses of acute respiratory failure, aspiration, history of aftercare following joint replacement and cystitis. The record lacked evidence of tuberculosis (TB) testing. On 4/4/18 at 2:30 PM licensed nurse C/Operator said the resident came from a long-term care facility and had the testing done there. He/she confirmed the record did not have evidence of the testing and he/she called the former facility for documentation. Licensed nurse C/Operator failed to follow tuberculosis (TB) guideline of a two-step testing method for TB which included the date of plantation, date read and the results of the testing for resident #701. - Record review on 4/4/18 at 2:40 PM for resident #702 revealed an admission date of 12/27/17 with diagnoses of hypertension, atrial fibrillation, type 2 diabetes, hypothyroidism and pneumonia. The record lacked evidence of tuberculosis (TB) testing. During an interview on 4/4/18 at 2:45 PM licensed nurse C/Operator stated the two-step TB skin test was not done. Licensed nurse C/Operator failed to follow tuberculosis (TB) guideline of a two-step testing method for TB which included the date of	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5230	Continued From page 33 plantation, date read and the results of the testing for resident #702.	S5230		
S5251 SS=F	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of 7 residents. The sampled included 3 residents and 2 focused reviews for safety concerns. Based on record review and interview licensed nurse C/Operator failed to ensure 3 of 5 sampled resident records included documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action take and results of the action (#701, #702 and #703). Findings included: - Record review for resident #701 on 4/4/18 revealed an admission date of 6/20/17 with diagnoses of acute respiratory failure, aspiration, history of aftercare following joint replacement and cystitis. The admission Functional Capacity Screen dated 6/20/17 indicated the resident required physical assistance with bathing, dressing, toileting, transfers, walk/mobility and continent of urinary	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5251	Continued From page 34	S5251		

bladder. He/she had impaired decision making with intact memory.

The Negotiated Service Agreement dated 6/20/17 indicated the resident had an indwelling catheter, required assistance of 2 staff for bathing, dressing, toileting and catheter needs, transfers and to walk/mobility.

The Health Services care plan dated 6/20/17 indicated the resident required 2 staff assist with transfers, dressing/undressing, bathing, toileting and an indwelling catheter.

Review of the nursing notes between 6/20/17 and 4/4/18 revealed an entry dated 6/20/17 at 8:40 PM regarding his/her admission. The next and only note was dated 6/30/17 without a time which indicate at 4:10 AM certified medication aide A called the licensed nurse C/Operator regarding the resident's complaint of pain in the right leg/hip area and not being able to urinate. The CMA stated he/she had found a straight catheter kit in the medication room and licensed nurse C/Operator advised CMA A to give the resident pain medication and nurse C would come to facility to perform the straight cath. The nurse recorded arrival at 4:40 AM and straight catheterized without difficulty-1050 cubic centimeters return. The nurse sent the physician a message advising him/her of the procedure and results. The physician ordered Foley catheter to be placed again. At 8:10 AM ordered Foley catheter from the pharmacy. Foley inserted at 3:10 PM without difficulty.

During an interview on 4/4/18 at 1:10 PM licensed nurse C/Operator stated he/she had taken documents home to work on updating the charts. He/she confirmed the resident's chart only had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5251	Continued From page 35 the 2 nursing notes. On 4/4/18 at 1:10 PM licensed nurse C/Operator removed a large envelope from a travel work bag which was about 4 inches thick with papers. From the envelope he/she removed 9 papers with the resident's name on it. Those pages included the following: A nursing note dated 6/20/17 2040 (8:40PM) about the resident's admission and was completed about half the page and signed off by licensed nurse C/Operator. A foot examination and treatment form dated 7/20/17. A surgery scheduling request with advanced orthopedic associates dated 7/26/17 which indicated the resident was scheduled for surgery on right hip on 8/7/17. Interdisciplinary notes from a long-term care facility dated 8/10/17 through 8/11/17 with information regarding the stay at the skilled nursing facility following the hip surgery. A radiology services request dated 9/5/17 with exam on 9/7/17. Mobile X-ray report dated 9/7/17 which showed no apparent complications post right hip replacement and another dated 11/18/17 which showed no loosening of right hip arthroplasty or acute fracture. A letter from Mid-Kansas Dermatology Clinic regarding removal of a lesion for the resident's scalp dated 2/5/18. The resident's record included the above information as well but was not reflected in the nursing notes to show complete and consistent care needs of the resident. Review of the physician's orders revealed the following orders without any documentation in the	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5251	Continued From page 36	S5251		

nursing notes regarding symptoms of illness or injury, action taken or results of the action:
8/6/17 Bactrim DS 1 by mouth twice a day for urinary tract infection (UTI)
Orders following surgery dated 8/7/17 directed resident may shower over the tan-colored dressing which stays in place 7-10 days. (the record lacked any information regarding as assessment of this area or that the dressing remained in place for the 7-10 days)
Orders for readmission to the facility on 8/14/17 to continue current medications and treatments. The nursing notes lacked any information regarding the readmission, status of the resident at the time of readmission or symptoms of illness or the absence of symptoms.
8/22/17 Indwelling Foley catheter with bag - "STAT" (immediately) size 16 French. (nursing notes lacked information regarding the symptoms or reason for the catheter. Whether the catheter was inserted, tolerance of procedure and result of the procedure)
8/24/17 Ciprofloxin 500 milligrams (mg) twice a day (BID) for 10 days and increase fluids for a UTI. (nursing notes lacked information regarding symptoms of illness, reason for antibiotic and result of the antibiotic)
8/31/17 indwelling Foley Catheter (3 piece) 16 French and UA (urinalysis). (nursing notes lacked information regarding the symptoms or reason for the catheter. Whether the catheter was inserted, tolerance of procedure and result of the procedure)
9/3/17 Cipro 250 mg by mouth (PO) twice a day for 10 days for UTI and increase fluids. (nursing notes lacked information regarding symptoms of illness, reason for antibiotic and result of the antibiotic)
10/9/17 Cipro 500 mg PO BID for 10 days for UTI. Recheck UA after treatment. STAT please.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5251	Continued From page 37 (nursing notes lacked information regarding symptoms of illness, reason for antibiotic and result of the antibiotic or follow-up UA obtained) 11/20/17 Tetracycline 250 mg PO four times a day for 10 days - recheck UA (nursing notes lacked information regarding symptoms of illness, reason for antibiotic and result of the antibiotic) 1/11/18 consult dermatology regarding lesion on the scalp and the left wrist. will need biopsy. (nursing notes lacked any information regarding the lesions) Post skin care treatment orders without a date from Mid-Kansas Dermatology clinic directed staff the resident had a scraping of a skin cancer and a burning. The tumor was removed and replaced by a scab. Over the next 2-3 weeks clean the area vigorously with tap water and a mild soap once a day attempting to remove all the burned debris. After cleaning apply petroleum jelly and use Band-Aid coverages as needed. (nursing notes did not include any of the information about the procedure, nursing assessment after the procedure, the daily cleaning and response to healing) 2/9/18 Cephalexin 500 mg PO three times a day for 10 days with a diagnoses or reason listed. (nursing notes lacked information regarding symptoms of illness, reason for antibiotic and result of the antibiotic) Inter-Agency transfer record dated 3/8/18 from a hospital with diagnoses of acute respiratory failure and aspiration. (the record lacked any information regarding a choking episode/aspiration, assessment following a incident or symptoms leading up to the hospitalization. 3/14/18 Physical therapy and Speech therapy swallow evaluation (nursing notes lacked any information regarding the resident having swallowing issues)	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5251	Continued From page 38	S5251		

3/14/18 Use 0/5% triamcinolone cream BID for 10 days on rash. (nursing notes lacked any information regarding a rash on any skin issues for the resident or result of the use of the cream)

Review of the July 2017 medication/treatment administration record (MAR/TAR) revealed directions to staff to flush the Foley catheter with 200 cubic centimeters daily for 10 days. The record included 4 initials of a nurse, and 5 initials of certified medication aide (CMA) staff as follows: 7/22/17, 7/23/17 and 7/25/17 initials of CMA G, 7/28/17 initials of CMA E and 7/29/17 initials of CMA K.

The December 2017 MAR/TAR included catheter change every 30 days without a start date but initialed as completed on 12/29/17 by CMA G.

The January 2018 MAR included change catheter every 30 days dated 1/9/18 and initialed as completed on 1/30/18 by CMA D.

The March 2018 MAR included the same order with initials of change on 3/1/18 and 3/24/18 by CMA G.

Review of the nursing notes between 6/20/17 and 4/4/18 revealed no information related to catheter changes or the flushes.

Interview on 4/5/18 at 11:30 AM with certified medication aide A revealed staff changed the resident's urinary catheter every time the staff obtained a urine sample. He/she stated the CMAs do the catheter removal and reinsertion.

Review of the laboratory results in the resident's record revealed staff obtained a urine specimen on the following days: 7/15/17, 8/1/17, 9/1/17,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5251	Continued From page 39 9/24/17, 10/16/17, 11/8/17, 11/27/17, 3/2/18 and 3/25/18. On 3/30/18 speech therapy B completed a swallow study and recommended a change in diet from mechanical soft to regular. The record lacked information regarding this evaluation, staff monitoring of the resident's swallowing tolerance or signs of difficulty and no orders from the physician to change the diet. Observation on 4/4/18 at 9:11 AM revealed direct care staff F removed a container of clear liquid from the resident and stated the water was not thickened and he/she was to have thickened liquids. Observation on 4/4/18 at 12:40 PM revealed staff had served the resident a regular diet which included a bowl of stew/soup with approximately 1/2-inch slices of a tubular sausage meat, chunks of potatoes and cabbage. He/she had a small bowl of diced fruit and a glass of red slightly thickened red liquid and a 4-ounce container of ice cream. He/she ate independently and he/she coughed a couple times during the meal but not while actively chewing/swallowing. During an interview on 4/4/18 at 2:02 PM with direct care staff F revealed the resident had choked on bacon and was admitted to the hospital in March 2018. When he/she returned the diet was mechanical soft with nectar thick liquids. The speech therapist evaluated him/her in the last week or so and he/she can have a regular diet with nectar thick liquids then regular liquids after oral care. Direct care staff F reported earlier that morning he/she removed the resident thin liquid water because the resident had not done the oral care after breakfast yet. He/she	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5251	Continued From page 40	S5251		

confirmed the resident received a regular diet with nectar thick liquids at the noon meal on 4/4/18.

Observation on 4/5/18 at 11:31 AM with certified medication aide A and E present revealed the resident continued to have a raised fine red scattered rash across the lower back and upper buttocks, upper thighs and a few on the lower legs. The resident reported the area itched at first but not now and staff put a cream on it.

During interview with licensed nurse C/Operator on 4/5/18 at 11:45 AM revealed he/she had text messages with pictures to and from the physician about the rash but none of this was part of the resident's legal record. On 4/5/18 at 3:30 PM he/she confirmed the nursing notes lacked information about all of the above symptoms, indications of illness with date/time of occurrence, action take and results of the action.

Licensed nurse C/Operator failed to ensure this resident's records included documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action take and results of the action.

- Record review for resident #702 on 4/4/18 at 2:40 PM revealed an admission date of 12/27/17 with diagnoses of hypertension, atrial fibrillation, type 2 diabetes, hypothyroidism and pneumonia.

Review of the admission Functional Capacity Screen (FCS) date 12/27/17 revealed the resident required physical assistance for bathing, dressing, toileting, transfers, walking/mobility, he/she unable to perform medication management/treatments and was at risk for falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5251	Continued From page 41 The Negotiated Service Agreement (NSA) dated 12/27/17 indicated the resident required 1 staff assistance with bathing/hair washing, dressing, toileting, transfers and ambulated with 1 staff assist and a walker. The NSA included fall monitoring and identified the resident as at risk. Under additional services not listed included staff would encourage resident to comply with all physical therapy instructions. The Health Service Care Plan dated 12/27/17 identified the resident needed staff assist of 1 for transfers, dressing, hygiene/grooming, bathing and toileting. Under personal information - resident had a fall resulting in left fractured hip prior to coming to the facility. Review of the nursing notes section between 12/27/17 and 4/4/18 revealed an entry from the physician dated 1/11/18 and a nursing note entry dated 1/11/18 which read -Dr.... here for resident admission assessment. Resident compliant. Labs orders and re-ordered annually. The note ended there and was not signed. During an interview on 4/4/18 at 3:00 PM licensed nurse C/Operator reported the resident went to the hospital for pneumonia and then went to another facility for skilled therapy and returned to this facility on 4/3/18. Licensed nurse C/Operator reported he/she called for a chest X-ray and within the hour he/she sent the resident to the hospital by Emergency Medical Services (EMS) where the resident was diagnoses with pneumonia. He/she handed the surveyor about 15 pages of copies of information he/she reported came with the resident from the other facility and he/she had not reviewed the papers yet or assessed the resident. He/she confirmed the nursing notes and record lacked any information	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5251	Continued From page 42	S5251		

regarding the resident's illness, symptoms leading up to the call for EMS, actions taken or result of those actions.

On 4/5/18 at 10:30 AM record review revealed a late entry for the events of 3/8/18 the late entry was dated 4/3/18 even though this record was not available for review on 4/4/18. The entry indicated on 3/8/18 without a time the resident coughing early that morning. auscultation of lungs showed upper lobes cleat and bases diminished with oxygen saturation 94%. Resident coughed a few times off and on throughout the day but stated, "I am feeling better." by the evening meal the resident did not look like he/she was feeling well. Auscultation of lungs-crackles and wheezes present at this time in upper lobes bilateral. Texted physician for order to get chest X-ray. At 6:42 PM called mobile X-ray who stated it would be a couple of hours. Approximately an hour to 1.5 hours later the resident's breathing became "loud" and more labored. Texted physician to let him/her know the resident was sending resident to the hospital instead of waiting for X-ray at 8:11 PM.

Review of the physician orders revealed the following:
2/8/17 Ciprofloxacin 500 milligrams (mg) by mouth (PO) twice a day (BID) for 7 days. There was a urinalysis (UA) report dated 2/5/18 with occasional bacteria, positive for blood and protein in the urine indicative of infection with a culture and sensitivity which showed proteus mirabills > 100,00 cfu/ml (calculate colony forming unit per milliliter). (nursing notes lacked any information regarding the symptoms leading up to the UA, monitoring of the antibiotic and the results of the action)
3/1/8 ciprofloxacin 500 mg PO BID for 10 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5251	Continued From page 43 UA results dated 2/26/18 revealed moderate bacteria, positive for blood and the culture and sensitivity again grew proteus mirabillis > 100,00 cfu/ml. (nursing notes lacked any information regarding the symptoms leading up to the UA, monitoring of the antibiotic and the results of the action) Interview with licensed nurse C/Operator on 4/5/18 at 3:45 PM confirmed the nursing notes lacked information about the resident UTI symptoms, illness and response to action taken. Licensed nurse C/Operator failed to ensure this resident's records included documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action take and results of the action. - Record review for resident #703 revealed an admission date of 6/14/13 with diagnoses of pneumonia and dementia. The annual Functional Capacity Screen dated 7/4/17 indicated the resident needed supervision with transfers, walking and had behavior of wandering. The Negotiated Service Agreement (NSA) dated 7/4/17 included the resident could ambulate independently with supervision. The NSA included behavioral directions of RN will be responsible for management of all behavioral issues of resident. The NSA did not include interventions related to wandering behavior. Under the toileting portion revealed toileting required 2 staff because the resident may be combative. Under the additional services not listed revealed staff must supervise to ensure the resident does not toilet in areas other than the	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5251	Continued From page 44	S5251		

toilet, the resident would remain appropriately dress to maintain dignity with no additional information related to wandering behavior.

The Health Services Care Plan dated 7/4/17 included resident could ambulate with supervision of 1 staff who would encourage the resident to use a walker for safety. Under behavior it included RN would report any inappropriate behavior to physician and report plan of action to power of attorney. Under personal information it included resident had Alzheimer's and will react to any "Negative" talk, negatively. Positive re-enforcement or distraction works better for resident. Supervise resident closely for his/her habit of toileting in trash cans, chairs etc. In addition, monitor resident for removing his/her clothing in public areas.

Review of the nursing notes revealed the last entry in the record was dated 8/22/16.

Telephone order dated 6/1/17 directed staff to increase the Fentanyl patch to 50 micrograms (a narcotic pain medication) and discontinue the Depakote (an anti-seizure medication also use to stabilize mood). The nursing notes lacked any information related to the resident having increase pain.

Telephone order dated 8/15/17 for chest X-ray to rule out sepsis, lethargy. The nursing notes lacked any information regarding the resident illness or symptom of illness.

A laboratory results dated 8/17/17 indicated the source of the specimen was blood/peripheral left arm which tested positive for gram positive cocci and staph observed in the gram stain. The nursing notes lacked any information regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5251	Continued From page 45 the resident's illness or symptoms of illness. A physician order dated 8/19/17 for Ceftriaxone 1-gram daily intramuscular. Doxycycline 100 milligrams twice a day until culture come back due to positive blood cultures. The nursing notes lacked information regarding the resident's illness and/or symptoms, actions taken and result of actions. During an interview on 4/9/18 at 3:10 PM licensed nurse C/Operator confirmed the record had no nursing notes since 8/22/16. Licensed nurse C/Operator failed to ensure this resident's records included documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action take and results of the action.	S5251		
S5258 SS=E	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (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 carehome; and	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5258	Continued From page 46 (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 work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(d)(3) The facility census totaled 7 residents. Based on interview and record review licensed nurse C/Operator failed to have evidence the registry was checked prior to working for 4 of 4 newly hired direct care providers (certified nurse aide F or certified medication aides D, E and G). Findings included: - The facility provided a list of 15 employees hired since last resurvey review. All 15 were direct care providers (certified nurse aide or certified medication aide). Review of the personnel records on 4/5/18 at 2:00 PM revealed the records lacked evidence of the facility checking with the registry before the following staff began working: certified medication aide #D with a hire date of 5/24/17, certified medication aide #E with a hire date of 7/5/17 and direct care staff with a hire date of 9/20/17. Certified medication aide G with a hire date of 5/15/17 had a registry verification dated 2/13/18. During and interview on 4/5/18 at 2:45 PM with licensed nurse C/Operator confirmed the personnel records of 4 newly hired direct care	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5258	Continued From page 47 staff or certified medication aides lacked evidence of checking prior to the date he/she began working. Licensed nurse C/Operator failed to have evidence the registry was checked prior to working for 4 of 4 newly hired direct care providers.	S5258		
S5313 SS=F	26-42-205 (g) (3) Over the counter medication (g) (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 the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(3) The facility reported a census of 7 residents. The sample included 3 residents. Based on observation and interview for all residents receiving facility management of medications, licensed nurse C/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	S5313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5313	Continued From page 48	S5313		

container.

Findings included:

- The resident roster identified 7 residents received facility management of medications.

Observation revealed on 4/4/18 at 9:17 AM certified medication staff G unlocked the only medication cart which contained opened over the counter (OTC) medication bottles stored in several of the cart drawers. The following items were labeled by partial first name of resident, first name of resident, stock or had no identification: for resident #702, Citracal + D3 with partial first name of resident, Centrum Silver with first name, Loratadine 10 milligrams (mg) with partial first name, Gentle lax with partial first name, Bayer Aspirin with partial first name. Resident #705, Flintstone vitamins with first name, (2 bottles) Bayer ASA 81 mg with first name. Resident #704 had a partially used container of Balmex adult care rash cream with his/her first name only. The OTC medications which were opened and had no name included B-12 1000 micrograms, dark chocolate probiotics, PB assist JR (junior strength probiotic digestive aid), refresh eye drops, Centrum Silver, Dulcolax tablets, a partially used tube of calmoseptine cream and a box labeled "open tube" of diaper rash cream. Medications labeled or identified as stock medications included Acetaminophen 500 mg (2 open bottles), antidiarrhea loperamide 2 mg (2 open bottles/packages), 3 bottles of liquid lidocaine 1% for injection with notation to use to dilute Rocephin dated 11/13/17, Preservision eye drops, Mucinex am/pm with Tylenol, cranberry 450 mg 60 soft gels and a bottle/package of probiotics. A bottle of Miralax with a pharmacy label which was partial torn off only had the last name of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5313	Continued From page 49 "resident-17 grams-mouth-twic" on the label. During an interview on 4/4/18 at 10:38 AM with licensed nurse C/Operator confirmed the OTC medications lacked the proper labeling with the full name of the resident. He/she reported the medications labeled as "stock" which were in the medication cart for residents were purchased for employee use and should not have been in the medication cart. For all residents receiving facility management of medications, licensed nurse C/Operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on each OTC medication package or container.	S5313		
S5370 SS=E	28-39-437 Construction (f) Sanitation and maintenance. Each facility shall provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. (g) Public telephone. There shall be a public telephone locally accessible to individuals with disabilities in a private area that allows a resident or another individual to conduct a private conversation. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(a) The facility reported a census of 7 residents with 3 sampled and 2 focused reviews. Based on observation and interview licensed nurse C/Operator failed to maintain dining room furniture in a safe and sanitary manner for	S5370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER 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
S5370	Continued From page 50 residents, staff and the public. Findings included: - Observation on 4/4/18 at 9:05 AM revealed 3 blue dining room chairs at the dining table with tall backs and covered in a vinyl material. The shoulder portion of each chair on both sides had rips with jagged edges, seam separation with the inner white material protruding out of the openings thereby creating an uncleanable surface. Observation on 4/4/18 at 12:30 PM revealed resident #703 sat in one of the blue chairs at the dining room table. Observation on 4/5/18 at 9:45 AM revealed the same chairs in the dining room. Interview on 4/4/18 at 10:18 AM with direct care staff F revealed 5 out of 7 residents ate their meals at the dining room table. Interview on 4/9/18 at 3:20 PM with licensed nurse C/Operator confirmed that at least 2 residents used the blue chairs and 5 out of the 7 sat at the dining room table. He/she confirmed the needed repairs or replacement of the chairs. Licensed nurse C/Operator failed to maintain dining room furniture in a safe and sanitary manner for residents, staff and the public.	S5370		