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	B087135	A. BUILDING: _____ B. WING _____	03/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLARK ADULT CARE HOME 2	254 S ROBIN ROAD WICHITA, KS 67209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with investigation of complaint #126073 and complaint #117538 of the above home plus facility on 2/28/18, 3/1/18, 3/5/18, and 3/6/18.	S 000		
S 100 SS=D	26-39-103 (a) RESIDENT RIGHTS a) Protection and promotion of resident rights. Each administrator or operator shall ensure the protection and promotion of the rights of each resident as set forth in this regulation. Each resident shall have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the adult care home. This STANDARD is not met as evidenced by: KAR 26-39-103(a) The facility reported a census of 8 residents and 1 adult day care resident. The sample included 3 residents and 3 discharged residents reviewed. Based on record review, interview, and observation for 1 (#400) of 3 residents sampled, the operator failed to ensure the resident had the right to a dignified existence and self-determination with access to services inside the adult care home. Findings included: - Record review for resident #400 revealed an admission date of 12/22/16 with diagnoses of dementia, congestive heart failure, coronary artery disease, hypertension, and macular degeneration.	S 100		

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

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S 100	Continued From page 1 Functional capacity screen dated 8/8/17 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and mobility/walking; was frequently incontinent of urine; and intact short-term memory, long-term memory, memory recall, and decision making. The functional capacity screen did not indicate resident had a current or recent problem with falls/unsteadiness. Negotiated service agreement/health care service plan dated 8/8/17 documented services provided by certified and licensed staff of supervision to one-person assistance to transfer; one-person assistance with walking using gait belt, walker, and oxygen tank; one-person assistance with toileting; staff assistance with incontinence management; and medication management. At 4:20 p.m. on 2/28/18, surveyor accompanied licensed nurse D to resident #400's room to test bathroom sink hot water temperature. Licensed nurse D stated he/she had to get key to unlock the bathroom door. Licensed nurse D stated we keep the bathroom door locked so resident will not go into bathroom without staff assistance and fall or mess with things stored in bathroom. During time in facility on 2/28/18 and 3/1/18, surveyor observed staff walk with resident with walker and gait belt and at times resident walked by self with walker. Interview with resident at 3:00 p.m. on 3/1/18. Resident alert and oriented and stated he/she did not like that staff kept his/her bathroom door locked. Surveyor checked door to bathroom and door locked. Resident stated staff locked the door because they were afraid he/she would fall. Resident pointed to a pull tab alarm on his/her	S 100		

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S 100	Continued From page 2 walker that he/she used to call for assistance to go to the bathroom and stated staff responded quickly. Resident stated he/she felt he/she had more freedom in the long-term care facility where he/she lived before moving to this facility. Note: resident received furosemide (diuretic) 40 milligrams daily. At 3:15 p.m. on 3/1/18, resident pulled the tab on alarm and certified staff F went to resident's room. Resident stated he/she needed to go to bathroom and certified staff F told resident he/she needed to go get the key to the bathroom door. Certified staff F returned to resident's room and assisted resident to the bathroom. Certified staff F stated to surveyor staff had kept bathroom door locked for the last month for resident's safety due to resident's unsteadiness. During an interview at 3:26 p.m. on 3/1/18, certified staff F stated resident required stand-by assistance with walking and toileting. Certified staff F stated he/she toileted resident every 2 hours and whenever resident called for assistance. Certified staff F stated resident had been more anxious about getting to the bathroom since bathroom door had been kept locked. The operator failed to ensure resident #400 had the right to a dignified existence and self-determination with access to services inside the adult care home.	S 100		
S 105 SS=D	26-39-103 (b) Exercise of Resident Rights (b) Exercise of rights. (1) The administrator or operator shall ensure that each resident is afforded the right to exercise	S 105		

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S 105	Continued From page 3 the resident ' s rights as a resident of the adult care home and as a citizen. (2) The administrator or operator shall ensure that each resident is afforded the right to be free from interference, coercion, discrimination, or reprisal from adult care home staff in exercising the resident's rights. (3) If a resident is adjudged incompetent under the laws of the state of Kansas, the resident ' s legal representative shall have the power to exercise rights on behalf of the resident. (4) In the case of a resident who has executed a durable power of attorney for health care decisions, the agent may exercise the rights of the resident to the extent provided by K.S.A. 58-625 et seq. and amendments thereto. This STANDARD is not met as evidenced by: KAR 26-39-103(b)(2) The facility reported a census of 8 residents and 1 adult day care resident. The sample included 3 residents and 3 discharged residents reviewed. Based on record review and interview for 1 (#100) of 3 discharged residents, the operator failed to ensure the resident was free from coercion and/or reprisal from adult care home staff. Findings included: - Record review for resident #100 revealed an admission date of 6/30/17, discharge date of 1/31/18, and diagnoses of schizophrenia, anxiety, depression, and chronic pain. Functional capacity screen dated 6/30/17 indicated resident did not experience impaired cognition and was independent with transferring	S 105		

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S 105	Continued From page 4 self and walking. Nurse's notes contained an entry by licensed nurse G at 7:00 p.m. on 10/29/17 that resident knew code to door and let someone in the facility. Licensed nurse G documented he/she notified operator of this and operator "advised resident never to open the door with or without code; if you do you will be asked to leave with no notice." During an interview at 5:00 p.m. on 3/1/18, reviewed the entry with administrative staff C who confirmed this was a verbal threat to resident. The operator failed to ensure resident #100 was free from coercion and/or reprisal from adult care home staff.	S 105		
S 195 SS=D	26-39-102 (f) Discharge Notice (f) The administrator or operator, or the designee, shall provide a notice of transfer or discharge in writing to the resident or resident ' s legal representative at least 30 days before the resident is transferred or discharged involuntarily, unless one of the following conditions is met: (1) The safety of other individuals in the adult care home would be endangered. (2) The resident's urgent medical needs require an immediate transfer to another health care facility. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(f)	S 195		

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S 195	Continued From page 5 The facility reported a census of 8 residents and 1 adult day care resident. The sample included 3 residents and 3 discharged residents reviewed. Based on record review and interview for 1 (#200) of 3 discharged residents reviewed, the operator failed to provide a written notice of transfer or discharge to the resident at least 30 days before the resident was transferred/discharged from the facility on 12/20/17. Findings included: - On 3/1/18, surveyor asked administrative staff C for the closed record of resident #200. At 11:07 a.m. on 3/1/18, administrative staff provided the resident's admission agreement dated 11/29/17 and stated this was the only paperwork available for the resident. Administrative staff C stated resident was admitted to the facility on 11/29/17 and utilized a wheelchair that was too small for the resident. An outside provider obtained a larger wheelchair for the resident 12/20/17 and this wheelchair would not fit through the bathroom door so resident was discharged from the facility on that day to another facility. Administrative staff C stated resident did not receive a written 30-day notice of involuntary transfer or discharge prior to being discharged to another facility. Review of the resident's admission agreement documented "Involuntary transfer or discharge. The health care center reserves the right to involuntarily transfer or discharge the Resident, in accordance with applicable law, following written notice of transfer or discharge planning. This contract shall terminate on the date of involuntary transfer or discharge. Except in an emergency or	S 195		

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S 195	Continued From page 6 other circumstance permitted by law, the Resident normally will be provided with at least thirty (30) days advance written notice of transfer or discharge planning by the Health Care Center." The operator failed to provide a written notice of transfer or discharge to resident #200 at least 30 days before the resident was transferred/discharged from the facility on 12/20/17.	S 195		
S5105 SS=E	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 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 26-42-202(a)(1)(2)(3) The facility reported a census of 8 residents and 1 adult day care resident. The sample included 3 residents and 3 discharged residents reviewed.	S5105		

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S5105	Continued From page 7 Based on record review and interview for 1 (#500) of 3 residents sampled, the operator failed to ensure the development of a written negotiated service agreement that included a description of services provided by an outside resource, the identification of the outside resource, and the party responsible for payment of the services provided by the outside resource. Based on record review and interview for 1 (#300) of 3 residents sampled, the operator failed to ensure the development of a written negotiated service agreement that included a description of services based on the resident's functional capacity screening. Findings included: - Record review for resident #500 revealed an admission date of 4/27/16 with diagnoses of dementia and muscle weakness. Significant change functional capacity screen dated 2/2/18 indicated resident was unable to perform bathing, dressing, toileting, transferring, mobility/walking, eating, and management of medications and treatments; was frequently incontinent of urine; experienced impaired short-term memory, long-term memory, memory recall, and decision making; current or recent problems and risks as falls/unsteadiness and impaired vision. Negotiated service agreement dated 2/2/18 documented facility certified staff provided physical assistance with all activities of daily living and provided medication administration. The resident's record contained a medical care provider's order dated 2/2/18 for resident to begin	S5105		

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S5105	Continued From page 8	S5105		

receiving services of a hospice for senile degeneration of brain. The negotiated service agreement lacked the name of the hospice, services provided by hospice, and the payment source for the services.

During an interview at 1:51 p.m. on 3/1/18, licensed nurse C stated resident received hospice services and this was not documented in the resident's negotiated service agreement. Licensed nurse D stated hospice supplied the resident's medications, assessment by hospice licensed nurse, and hospice aide assisted facility certified staff to bathe resident.

The operator failed to ensure the development of a written negotiated service agreement for resident #500 that included a description of services provided by an outside resource, the identification of the outside resource, and the party responsible for payment of the services provided by the outside resource.

- Record review for resident #300 revealed an admission date of 1/29/18 with a diagnosis of dementia.

Functional capacity screen dated 1/29/18 indicated resident experienced impaired short-term memory, long-term memory, memory recall, and decision making and was unable to perform management of medications.

Negotiated service agreement dated 1/29/18 documented resident self-administered medications and family ordered and delivered medications to facility.

During an interview at 2:12 p.m. on 3/1/18, licensed nurse D stated facility certified

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S5105	Continued From page 9 medication aides administered medications to the resident and reordered resident's medication from the pharmacy. The operator failed to ensure the development of a written negotiated service agreement for resident #300 that included a description of services based on the resident's functional capacity screening.	S5105		
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 8 residents and 1 adult day care resident. The sample included 3 residents and 3 discharged residents reviewed. Based on interview, observation, and record review for all residents, the operator failed to demonstrate the provision of a sufficient number of staff on duty at all times to take residents who required physical assistance of 1 to 2 certified staff to transfer to a secure location in the event of an emergency or disaster. Findings included: - Review of the resident roster revealed resident #510 and resident #513 each required	S5205		

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S5205	Continued From page 10 two-person transfer assistance. During tour of the facility at 1:40 p.m. on 2/28/18, surveyor observed resident #510 in bed in his/her room. A mechanical lift was in the resident's room. Operator stated resident required a mechanical lift for transferring. Also during tour, surveyor observed resident #513 in a wheelchair in the living room. Record review for resident #300 revealed a diagnosis of dementia. Functional capacity screen dated 1/29/18 indicated resident was independent with transferring and walking; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and exhibited wandering behavior. Negotiated service agreement documented resident would require one-person assistance to exit the facility. During time in facility on 2/28/18 and 3/1/18, surveyor observed resident wander throughout facility and required redirection from certified staff. Record review for resident #500 revealed diagnoses of dementia and muscle weakness. Functional capacity screen dated 2/2/18 indicated resident was unable to transfer self, unable to walk or mobilize self, and required a wheelchair for mobility. Negotiated service agreement/health care service plan dated 2/2/18 documented resident required one to two-person transfer assistance and would require one-person assistance to propel wheelchair to exit the facility. During time in the facility on 2/28/18 and 3/1/18, surveyor observed resident sitting in wheelchair or a chair in living room. Resident did not attempt to mobilize self. Record review for resident # 400 revealed diagnoses of dementia, congestive heart failure,	S5205		

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S5205	Continued From page 11	S5205		

and coronary artery disease. Functional capacity screen dated 8/8/17 indicated resident required physical assistance with transferring and walking with gait belt, walker, and oxygen tank. During time in facility on 2/28/18 and 3/1/18, surveyor observed staff walk with resident with walker and gait belt and at times resident walked by self with walker. Staff wheeled oxygen concentrator to dining room for resident to use during meals.

On 2/28/18, surveyor observed residents #511 and #514 each required certified staff member assistance to ambulate. Resident #512 ambulated independently with a walker.

During an interview at 1:50 p.m. on 2/28/18 operator stated a staffing pattern of 2 certified staff worked 6:00 a.m. to 2:00 p.m.; 2 certified staff worked 2:00 p.m. to 10:00 p.m.; and 1 certified staff worked 10:00 p.m. to 6:00 a.m. plus a "sleeper" (certified staff) to help if needed.

During an interview at 1:20 p.m. on 3/1/18, administrative staff C stated the house did not have a fire sprinkler system. Administrative staff C provided documentation of "Disaster & Emergency Preparedness Drill" dated 5/30/17 with evacuation of residents by 1 staff member in 3 minutes. The document recorded the names of 3 residents and administrative staff C stated these 3 residents required two-person transfer assistance and were not evacuated from the building. Administrative staff C stated the one staff member evacuated residents #514, #511, #500, #400, and #600 (this resident discharged 6/26/17) from the building.

The operator failed to demonstrate the provision of a sufficient number of staff on duty at all times to take residents who required physical

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S5205	Continued From page 12 assistance of 1 to 2 certified staff to transfer to a secure location in the event of an emergency or disaster.	S5205		
S5240 SS=D	26-42-105 (a) Resident Records (a) The administrator or operator of each home plus shall ensure the maintenance of a record for each resident in accordance with accepted professional standards and practices. (1) Designated staff shall maintain the record of each discharged resident who is 18 years of age or older for at least five years after the discharge of the resident. (2) Designated staff shall maintain the record of each discharged resident who is less than 18 years of age for at least five years after the resident reaches 18 years of age or at least five years after the date of discharge, whichever time period is longer. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(a)(1) The facility reported a census of 8 residents and 1 adult day care resident. The sample included 3 residents and 3 discharged residents reviewed. Based on record review and interview for 1 (#200) of 3 discharged residents reviewed, the operator failed to maintain the resident's record after the discharge of the resident. Findings included: - On 3/1/18, surveyor asked administrative staff C for the closed record of resident #200.	S5240		

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S5240	Continued From page 13 At 11:07 a.m. on 3/1/18, administrative staff provided the resident's admission agreement dated 11/29/17 and stated this was the only paperwork available for the resident. Administrative staff C stated resident was admitted to the facility on 11/29/17 and utilized a wheelchair that was too small for the resident. An outside provider obtained a larger wheelchair for the resident 12/20/17 and this wheelchair would not fit through the bathroom door so resident was discharged from the facility on that day to another facility. Administrative staff C stated resident's record was sent with the resident and not maintained in this facility. The operator failed to maintain resident #200's record after the discharge of the resident.	S5240		
S5251 SS=D	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 8 residents and 1 adult day care resident. The sample included 3 residents and 3 discharged residents reviewed. Based on record review and interview for 1 (#300) of 3 residents sampled, the licensed nurse failed to ensure the resident's record contained documentation of the action taken for symptoms	S5251		

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(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 14 of illness and the results of the action. Findings included: - Record review on 2/28/18 for resident #300 revealed an admission date of 1/29/18 with diagnosis of dementia. Functional capacity screen dated 1/29/18 indicated resident experienced impaired short-term memory, long-term memory, memory recall, and decision making; was continent of urine; and was unable to perform management of medical treatments. Negotiated service agreement dated 1/29/18 documented staff provided management of medical treatments. Nurse's notes contained an entry by licensed nurse D on 2/27/18 that staff reported resident having increased behaviors. Licensed nurse D documented he/she contacted resident's medical care provider and received order to obtain urine specimen via straight catheter for urinalysis and culture and sensitivity if indicated. The record lacked documentation of the completion of urinary catheterization to obtain a urine specimen. During an interview at 2:12 p.m. on 3/1/18, licensed nurse D stated resident voided on own to provide a urine specimen for urinalysis. Licensed nurse D stated he/she did not document this and stated the straight catheter order was meant for another resident. The licensed nurse failed to ensure the record of resident #300 contained documentation of the	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087135	A. BUILDING: _____ B. WING _____	03/06/2018

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S5251	Continued From page 15 action taken for symptoms of illness and the results of the action.	S5251		