STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET WICHITA, KS 67212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	INITIAL COMMENTS The following citations represent the findings of a revisit for notice of assessment 17-122 and ban on admission 17-19 of the above home plus facility on 1/9/18, 1/10/18, 1/11/18, and 1/16/18.	{S 000}		
S5095 SS=D	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(d) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review and interview for 1 (#5011) of 3 residents sampled, licensed nurse C failed to ensure that the resident's functional capacity at the time of screening was accurately reflected on that resident's screening form. Findings included: - Record review for resident #5011 revealed an admission date of 10/11/16 and diagnoses of traumatic brain injury and type 2 diabetes mellitus. Functional capacity screen dated 11/28/17 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; a wheelchair for mobility; was	S5095		

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
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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
S5095	Continued From page 1	S5095		

occasionally incontinent of urine; was at risk for falls; and experienced impaired short term memory, memory recall, and decision making.

Negotiated service agreement/health care service plan dated 11/28/17 documented resident exhibited a behavior of putting soiled clothing with clean clothing.

Review of the medication administration notebook revealed documentation of listed behaviors resident exhibited that included failed to ask for assistance with toileting, poured urine onto carpet/floor, placed soiled clothing into hamper without telling staff, stopped up toilet and then flooded bathroom floor, and smeared feces around room and on self. The document contained areas for staff to initial when resident exhibited a behavior.

The record contained wellness notes (documentation by licensed nurses) of resident's behaviors as follows:

11/30/17 at 2:00 p.m. licensed nurse C documented it was reported that resident had feces on carpet and resident "rubbed it into carpet with shoe."

12/25/17 at 6:00 p.m. licensed nurse C documented resident behaviors of urinating on floor and chewing paper.

1/1/18 at 5:20 p.m. licensed nurse D documented resident "seems to have improved outbursts and relating better with staff and residents."

1/7/18 at 5:45 p.m. licensed nurse C documented behaviors of a verbal outburst by resident targeted at another resident, inappropriate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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
S5095	Continued From page 2 discarding of urine, and getting feces on clothing and bedding. The functional capacity screen lacked documentation to indicate resident exhibited socially inappropriate behaviors. During an interview at 11:30 a.m. on 1/10/18, licensed nurse C stated when he/she conducted resident's functional capacity screen on 11/28/17 he/she had been told by staff that resident exhibited behaviors. Licensed nurse C failed to ensure that resident #5011's functional capacity at the time of screening was accurately reflected on that resident's screening form.	S5095		
{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 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. Based on record review, interview, and observation for 3 (#5010,	{S5155}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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 3 #5011, and #5012) of 3 residents sampled, owner/operator/licensed nurse B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Review of resident #5010's medical record revealed an admission date of 5/3/2017 and included a diagnosis of epilepsy. Review of the functional capacity screen dated 11/29/17 identified the resident could not manage his/her own medications and had current/recent problems with falls/unsteadiness. Review of the resident's negotiated service agreement/health care service plan (NSA/HCSP) dated 11/28/17 lacked direction for certified staff as to care and services they needed to provide during and after the resident had a seizure. During an interview on 1/10/18 at 10:55 AM certified staff F reported when the resident had a seizure he/she helped the resident to the floor but sometimes the resident wanted to go to his/her room so staff F helped the resident to his/her room. Staff F stated he/she also called the nurse to let them know the resident had a seizure, wrote it on the log and would go and check on the resident every few seconds to make sure they were OK. During an interview on 1/10/18 at 11:36 AM licensed nursing staff D reported he/she expected the certified staff to assist the resident to the floor if standing, stay with the resident while having a	{S5155}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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	{S5155}		

seizure to ensure the residents' safety. Staff D then expected the certified staff to call the nurse and inform them of the seizure. Staff D reviewed the NSA/HCSP and confirmed it lacked direction for the care and services the certified staff needed to provide when the resident had a seizure.

Owner/operator/licensed nurse B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs for resident #5010 when he/she had a seizure.

- Record review for resident #5011 revealed an admission date of 10/11/16 and diagnoses of traumatic brain injury and type 2 diabetes mellitus.

Functional capacity screen dated 11/28/17 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; a wheelchair for mobility; was occasionally incontinent of urine; was at risk for falls; and experienced impaired short term memory, memory recall, and decision making.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 11/28/17 indicated with an 'X' that certified staff members were responsible for assisting resident with management of socially inappropriate behavior of "putting soiled clothing with clean clothing."

Review of the medication administration notebook revealed documentation of listed behaviors resident exhibited that included failed to ask for assistance with toileting, poured urine onto carpet/floor, placed soiled clothing into hamper without telling staff, stopped up toilet and then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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 flooded bathroom floor, and smeared feces around room and on self. The document contained areas for staff to initial when resident exhibited a behavior. The record contained wellness notes (documentation by licensed nurses) of resident's behaviors as follows: 11/30/17 at 2:00 p.m. licensed nurse C documented it was reported that resident had feces on carpet and resident "rubbed it into carpet with shoe." 12/25/17 at 6:00 p.m. licensed nurse C documented resident behaviors of urinating on floor and chewing paper. 1/1/18 at 5:20 p.m. licensed nurse D documented resident "seems to have improved outbursts and relating better with staff and residents." 1/7/18 at 5:45 p.m. licensed nurse C documented behaviors of a verbal outburst by resident targeted at another resident, inappropriate discarding of urine, and getting feces on clothing and bedding. Medical care provider's orders included an order for monthly weight of resident. Resident records lacked documentation of a monthly weight. During an interview at 11:30 a.m. on 1/10/18, licensed nurse C confirmed the resident's NSA/HCSP lacked interventions to address management of resident's behaviors. Licensed nurse C stated staff did not weigh resident every month because resident could not stand and would discuss this with medical care provider on next visit.	{S5155}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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 Owner/operator/licensed nurse B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #5011 and were in accordance with the functional capacity screening and the negotiated service agreement. - Record review for resident #5012 revealed an admission date of 11/22/16 and diagnoses of type 2 diabetes mellitus and anxiety. Functional capacity screen dated 11/24/17 indicated resident required physical assistance with transferring and mobility; was at risk for falls; was usually continent of urine; and experienced impaired short term memory and memory recall. Negotiated service agreement/health care service plan (NSA/HCSP) dated 12/14/17 documented supervision or physical assistance as needed to transfer and supervision with mobility in wheelchair. NSA/HCSP documented intervention to address resident's risk for falls as "Bedrail to be applied on outside of bed to prevent falling out of bed during night due to vivid dreams." NSA/HCSP documented an outside resource provided wound care. Review of the aide communication book (certified staff members' documentation of resident care and incidents during the 8 hour shift) revealed the following: 12/2/17 first shift resident fell from bed, assisted resident up, and there were no injuries. 12/11/17 (no shift documented) of instruction to apply skin protectant on left side of "bum" to heal wound completely. 1/6/18 first shift resident complained of pain in bottom and stated when he/she was sitting it felt	{S5155}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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	{S5155}		

like he/she was sitting on glass.

NSA/HCSP lacked any additional interventions to address resident's risk for falls. NSA/HCSP lacked interventions to promote wound healing and to prevent further skin breakdown.

Wellness notes contained an entry on 12/27/17 by licensed nurse D documented wound to thigh resolved. At 5:00 p.m. on 1/1/17 licensed nurse D documented wound on left thigh remains closed. At 4:00 p.m. on 1/6/18, licensed nurse C documented "no skin issues at this time.

Comparison of the medical care provider's orders and the December 1 through 31, 2017 medication administration record (MAR) revealed resident to receive Glucerna (nutritional drink high in protein) shake 1 can three times a day. The December 2017 MAR lacked documentation that resident received any Glucerna shakes. The record lacked a medical care provider's order to discontinue Glucerna.

On arrival to the facility on 1/9/18 at 1:20 p.m. surveyor observed resident #5012 sitting in a wheelchair at a table in the dining area. Again on 1/10/18 at 9:20 a.m. surveyor observed resident sitting in a wheelchair at same table.

During an interview at 11:07 a.m. licensed nurse D stated resident did not have any skin issues at present. Licensed nurse D reviewed NSA/HCSP and stated intervention to prevent skin breakdown was the use of a bed rail on bed because resident could reposition self with use of side rail. No other interventions to address prevention of skin breakdown in NSA/HCSP. Licensed nurse D stated he/she was not aware that resident fell from bed. Licensed nurse D confirmed the only

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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 intervention to address resident's risk for falls was the bed rail when resident was in bed. Licensed nurse D stated resident did not like the taste of Glucerna shakes and likely refused the drink in December. Licensed nurse D stated he/she did not notify resident's medical care provider regarding resident's refusal. At 12:25 p.m. when asked to describe interventions and care provided to address resident's risk for falls and to prevent skin breakdown, certified staff F stated "I check on (resident) all the time" and assist with toileting and transferring. Owner/operator/licensed nurse B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #5012 and were in accordance with the functional capacity screening and the negotiated service agreement.	{S5155}		
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. The	S5195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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 9	S5195		

sample included 3 residents. Based on observation and interview for all residents, owner/operator/licensed nurse B failed to ensure all food was stored under safe and sanitary conditions and that containers of cleaning supplies were not stored in areas used for food storage.

Findings included:

- During tour of the kitchen food storage areas at 9:29 a.m. on 1/10/18, surveyor observed the following improper storage of food and outdated food items:

Freezer section of refrigerator:
Hash brown potato patties in plastic bag without date opened
Corn dogs in plastic bag unable to read date opened
Neapolitan ice cream without date opened
Rainbow sherbet opened 12/25/17 covered with ice crystals

Refrigerator:
White rice labeled as prepared 12/30/17
Stir fry rice labeled as prepared 1/5/18
Spaghetti and meat sauce labeled as prepared 1/3/18
Cottage cheese with best by date of 12/18/17 and marked as opened 12/26/17
Cottage cheese opened 11/27/17

Upright freezer:
Opened food items in plastic storage bags with no labeled open date included
One bagel
Teriyaki stir-fry
French fries
Chicken breast nuggets

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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 10 One plastic bag with what looked like a chicken breast Two plastic bags with hamburger patties covered with ice crystals Two slices of bacon in an open package Open bag of tator tots not tightly sealed Wire basket on top of refrigerator with 6 apples with soft spots and 2 bananas with brown spots Food items in upper cabinets without open date documented: Graham crackers Saltine crackers Cheese crackers Oyster crackers Italian style bread crumbs Brown sugar package not tightly sealed Items opened and expired: Two boxes of baking soda, one with best by date 10/12/17 and the other 2/26/17 Corn meal best by date of 4/10/17 Other items: Open container of Italian bread crumbs with handwriting of "Mixed ingredients for fish fillets 9/20/17." Plastic container labeled "Crunchy granola" with contents of possibly Chex cereal Three plastic containers, one with flour, one with sugar, and one with rice. A plastic scoop was stored in each container. Opened Plastic bottle of tartar sauce with package instructions to refrigerate after opening Cabinet under kitchen sink without a locking device contained: One gallon of Clorox bleach Spray bottle of shower cleaner	S5195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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 11 2 bottles of vegetable oil Pancake syrup 10# and a partial bag of potatoes 5 cans of soda in original package marked as belonging to a resident. Surveyor observed the box holding the soda was wet and stained. Surveyor noted cabinet wet under the sink drain pipe. Cabinet next to sink stored liquid fabric softener and 1 gallon of bleach. At 12:07 p.m. on 1/10/18, surveyor observed 7 residents in the dining area being served lunch. Surveyor observed that certified staff F wore gloves to use an ice scoop to fill a drink glass with ice. Certified staff F placed the ice scoop with handle on the ice, served drink to a resident, and returned to scoop ice in a glass for the next resident. During an interview at 11:45 a.m. on 1/10/18, owner/operator/licensed nurse informed of outdated food items, opened foods not dated with date opened, opened food items not tightly sealed, cleaning supplies stored with food items, and unlocked cleaning supplies. Owner/operator/licensed nurse B stated staff member E was responsible to discard outdated food items and all employees knew to tightly close and date opened food packages, and that chemicals were to be stored in a locked cabinet and not stored with food items. Owner/operator/licensed nurse B failed to ensure all food was stored under safe and sanitary conditions and that containers of cleaning supplies were not stored in areas used for food storage.	S5195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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 12	S5251		
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 7 residents. The sample included 3 residents. Based on record review and interview for 1 (#5012) of 3 residents sampled, owner/operator/licensed nurse B failed to ensure the resident's record contained documentation of an incident, action taken, and results of the action. Findings included: - Record review for resident #5012 revealed an admission date of 11/22/16 and diagnoses of type 2 diabetes mellitus and anxiety. Functional capacity screen dated 11/24/17 indicated resident required physical assistance with transferring and mobility; was at risk for falls; and experienced impaired short term memory and memory recall. Negotiated service agreement/health care service plan (NSA/HCSP) dated 12/14/17 documented supervision or physical assistance as needed to transfer and supervision with mobility in wheelchair. NSA/HCSP documented intervention	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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 13 to address resident's risk for falls as "Bedrail to be applied on outside of bed to prevent falling out of bed during night due to vivid dreams." Review of the aide communication book (certified staff members' documentation of resident care and incidents during the 8 hour shift) revealed certified staff G documented on first shift 12/2/17 that resident fell from bed, assisted resident up, and there were no injuries. Resident's record lacked documentation of the fall and an assessment by a licensed nurse. During an interview at 11:21 a.m. on 1/10/18, licensed nurse C stated he/she "Probably assessed (resident) and did not document" the incident and assessment. Owner/operator/licensed nurse B failed to ensure the resident's record contained documentation of an incident, action taken, and results of the action.	S5251		
{S5300} SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for	{S5300}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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
{S5300}	Continued From page 14 which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review and interview for 2 (#5010 and #5011), owner/operator/licensed nurse B failed to ensure medications were administered to residents in accordance with medical care provider's written orders and professional standards of practice. Findings included: - Review of resident #5010's medical record revealed an admission date of 5/3/2017 and included a diagnosis of epilepsy. Review of the functional capacity screen dated 11/29/17 identified the resident could not manage his/her own medications. Review of the negotiated service agreement/health care service plan dated 11/29/17 revealed certified staff were to administer medications and provide constant encouragement for medication compliance. Review of the December 2017 Medication Administration Record (MAR) revealed the resident had the following medication orders: Abilify 20 mg daily for schizophrenia Eliquis 2.5mg twice a day for clot prevention	{S5300}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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
{S5300}	Continued From page 15 Lamictal 225mg twice a day for seizure prevention Keppra 1500mg twice a day for seizure prevention Sinemet 25/100 three times a day for Parkinson's Gabapentin 100mg daily for neuropathy Senna-S 8.6/50mg daily for constipation Colace 100mg daily for constipation Calcium 600mg + Vit. D daily for supplement Fosamax 70 mg 1 time weekly (Sunday) for osteoporosis Melatonin 5 mg daily for insomnia The MAR revealed the resident refused all physician ordered medication from 12/7/17 through 12/15/17 which included Keppra and Lamictal (medications to prevent seizures). Review of the nurse's notes from 12/7/17 revealed the licensed nurse D identified the resident refused medications on 12/7, 8, 12/17 but lacked any evidence the medical provider was notified of the resident's refusal of medications. The nurse's notes also revealed that on 12/14/17 at 10:00 PM the resident had a seizure while out of the facility and went to the emergency department for evaluation and then returned to the facility at 12:30 AM on 12/15/17. The notes revealed the medical provider was faxed discharge orders from the hospital on 12/15/17 at 9:00 PM. During an interview on 1/10/18 at 9:20 AM certified care staff F reported he/she called the nurse when a resident refused their medications and the nurse would then talk to the resident about it. During an interview on 1/10/18 at 10:57 AM Licensed nursing staff D reported he/she believed	{S5300}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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
{S5300}	Continued From page 16	{S5300}		

he/she spoke to the medical provider about the resident's refusal to take his/her medications but was unable to provide any evidence the medical provider knew the resident had refused to take his/her medications.

During an interview on 1/10/18 at 11:45 AM owner/operator/Licensed nurse B reported he/she had spoken to the licensed nurses in the past and they knew they were to notify the medical provider when a resident refused medications.

Owner/operator/licensed nurse B failed to ensure licensed nurses followed professional standards of practice when resident #5010 refused to take his/her medications as ordered.

- Record review for resident #5011 revealed an admission date of 10/11/16 with diagnoses of traumatic brain injury and type 2 diabetes mellitus.

Functional capacity screen dated 11/28/17 indicated resident was unable to perform management of medications.

Negotiated service agreement/health care service plan dated 11/28/17 documented medication management and administration by certified medication aides and licensed nurse.

Review of the 12/1/17 through 12/31/17 medication administration record (MAR) revealed resident to receive Ambien (sleep aid) 10 milligrams by mouth daily at 8:00 p.m. On 12/18/17, certified staff E circled his/her initials and documented on the MAR medication not given "waiting on pharmacy to deliver."

During an interview at 11:45 a.m. on 1/10/18,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R-C 01/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET 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
{S5300}	Continued From page 17 owner/operator/licensed nurse B could not explain why the medication was not available for resident. Owner/operator/licensed nurse B failed to ensure medications were administered to resident #5011 in accordance with medical care provider's written orders and professional standards of practice.	{S5300}		