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 _____	07/13/2017

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 resurvey with investigation of complaint #117175 and complaint #118081 of the above home plus facility on 6/26/17, 6/27/17, 6/28/17, 6/29/17, 7/10/17, 7/11/17, 7/12/17, and 7/13/17.	S 000		
S 110 SS=D	26-39-103 (c) NOTICE OF RIGHTS AND SERVICES (c) Notice of rights and services. (1) Before admission, the administrator or operator shall ensure that each resident or the resident's legal representative is informed, both orally and in writing, of the following in a language the resident or the resident ' s legal representative understands: (A) The rights of the resident; (B) the rules governing resident conduct and responsibility; (C) the current rate for the level of care and services to be provided; and (D) if applicable, any additional fees that will be charged for optional services. (2) The administrator or operator shall ensure that each resident or the resident ' s legal representative is notified in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care. This STANDARD is not met as evidenced by: KAR 26-39-103(c)(1)(C) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records reviewed. Based	S 110		

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 _____	07/13/2017

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 110	Continued From page 1 on record review and interview for 1 (#103) of 3 residents sampled, owner/operator/licensed nurse B failed to provide to the resident, in writing before admission, the current rate for the level of care and services to be provided. Findings included: - Record review for resident #103 revealed an admission date of 5/3/17 and diagnoses of schizophrenia, epilepsy, and hypertension. Functional capacity screen dated 5/3/17 indicated resident required physical assistance with bathing, dressing, and toileting; supervision with transferring and ambulation; was independent with eating; was unable to perform management of medications and treatments; was usually continent; experienced impaired short-term memory and memory recall; and was at risk for falls. Negotiated service agreement and health care service plan each dated 5/3/17 documented facility to provide services of physical assistance with bathing; supervisor with dressing, toileting, walking, transferring, and grooming; meal preparation; housekeeping and laundry; and medication and treatment management and administration. Review of the admission agreement dated 5/3/17 revealed the lack of the monthly dollar amount to be paid by resident to the facility for care and services. At 3:44 p.m. owner/operator/licensed nurse B confirmed he/she did not inform the resident in writing before admission of the rate to be paid for care and services.	S 110		

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 _____	07/13/2017

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 110	Continued From page 2 Owner/operator/licensed nurse B failed to provide to resident #103, in writing before admission, the current rate for the level of care and services to be provided.	S 110		
S 185 SS=D	26-39-102 (d) Admission, Transfer, Discharge (d) The administrator or operator of each adult care home shall ensure that each resident is permitted to remain in the adult care home and is not transferred or discharged from the adult care home unless one of the following conditions is met: (1) The transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the current adult care home. (2) The safety of other individuals in the adult care home is endangered. (3) The health of other individuals in the adult care home is endangered. (4) The resident has failed, after reasonable and appropriate notice, to pay the rates and charges imposed by the adult care home. (5) The adult care home ceases to operate. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(d)(1)(2)(3)(4)(5) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on record review and interview for 1 (#106) of 3 residents sampled, owner/operator/licensed nurse B failed to ensure the resident was permitted to remain in the facility	S 185		

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 _____	07/13/2017

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 185	Continued From page 3	S 185		

and was not discharged from the facility unless one of the following conditions was met: resident's needs could not be met in the current facility; safety of other individuals in the facility was endangered; the health of other individuals in the facility was endangered; resident failed to pay the rates and charges imposed by the facility; or the facility ceased to operate.

Findings included:

- Record review for resident #106 revealed an admission date of 2/22/17 and diagnoses of schizophrenia, major depressive disorder, and anxiety disorder.

Functional capacity screen dated 2/22/17 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and mobility in wheelchair; unable to perform management of medications and treatments; was usually continent of urine; experienced impaired short-term memory and memory recall; and was at risk for falls.

Negotiated service agreement and health care service plan each dated 2/22/17 documented facility services of physical assistance with bathing 3 times a week, dressing, toileting, transferring, mobility in wheelchair, and medication and treatment administration by certified staff and licensed staff.

Record contained a "Smoking Contract" that outlined an agreement between facility and resident to allow resident to smoke outside without staff accompanying resident every 2 hours starting at 7:30 a.m. and ending at 9:00 p.m. and facility to store resident's cigarettes and lighter.

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 _____	07/13/2017

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 185	Continued From page 4 Record contained "Discharge of Resident" dated 6/10/17 that documented "Conditions that may result in an immediate discharge will be as follows: An infectious disease Uncontrolled behaviors endangering the health and safety of themselves, other residents. Resident's urgent medical needs require immediate transfer to another health care facility such as a hospital. Residents can be issued a 30-day discharge due to needs that cannot be met by the facility. Failure to pay the rates and charges as agreed to after reasonable notice, or the adult care home ceases to operate." The "Discharge of Resident" contained an "in conclusion" statement of "Due to un reconcilable differences between (name of facility) and (name of resident) both parties agree to discontinue services no later than the date of July 10, 2017, 30 days following the original agreed notice date of June 10, 2017." The discharge notice contained the signature of a person on the line labeled "administrator", signature of owner/operator/licensed nurse B, and signature of resident #106 with each signature dated 6/10/17. Further review of the resident's record revealed the lack of documentation by owner/operator/licensed nurse B or by a medical care provider that resident had an infectious disease, uncontrolled behaviors that endangered	S 185		

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 _____	07/13/2017

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 185	Continued From page 5	S 185		

self or others, urgent medical needs or other needs that could not be met by facility, or resident's failure to pay for care and services.

At 3:36 p.m. on 6/26/17, resident #106 confirmed he/she signed something about a 30-day notice but did not receive a copy of what he/she signed. Resident #106 asked (owner/operator/licensed nurse B) for a copy of the notice but was told the notice would be kept in (resident's) file. Resident #106 stated he/she was given the notice to sign after he/she reported an employee to (owner/operator/licensed nurse B). Resident stated he/she was currently looking for a place to live.

During an interview at 3:02 p.m. on 6/27/17 resident #106 stated he/she received shower assistance 3 times a week but was independent with dressing, toileting, transferring and walking. Resident did not state any health care needs the facility could not provide.

At 4:00 p.m. on 6/27/17, when asked for reason resident #106 was being discharged from the facility, owner/operator/licensed nurse B stated resident had become more difficult, was disrespectful of staff, and had "exchanged words" with another resident. When asked what healthcare need facility could not meet for resident, owner/operator/licensed nurse B stated resident's request to smoke every hour when agreed to every 2 hours.
Owner/operator/licensed nurse B stated staff members did not have time to stop and give resident a cigarette when resident requested.
Owner/operator/licensed nurse stated resident's family had given resident cigarettes and lighter to keep in resident's room and
owner/operator/licensed nurse B felt this

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 _____	07/13/2017

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 185	Continued From page 6 endangered other residents. Owner/operator/licensed nurse B stated there had not been evidence of resident smoking inside facility. During time in the facility on 6/26/17 and 6/27/17, observed resident ambulatory and able to go outside unassisted to smoke. Observed staff members had time to provide a cigarette to resident when he/she requested. Surveyor observed resident return lighter to staff member when he/she came back into facility. Owner/operator/licensed nurse B failed to ensure resident #106 was permitted to remain in the facility and was not discharged from the facility unless one of the following was met: resident's needs could not be met in the current facility; safety of other individuals in the facility was endangered; the health of other individuals in the facility was endangered; resident failed to pay the rates and charges imposed by the facility; or the facility ceased to operate.	S 185		
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.	S 195		

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 _____	07/13/2017

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 195	Continued From page 7 This REQUIREMENT is not met as evidenced by: KAR 26-39-102(f) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on record review and interview for 1 (#106) of 3 residents sampled, owner/operator/licensed nurse B failed to provide a notice of discharge in writing to the resident at least 30 days before resident was discharged involuntarily. Findings included: - Record review for resident #106 revealed an admission date of 2/22/17 and diagnoses of schizophrenia, major depressive disorder, and anxiety disorder. Functional capacity screen dated 2/22/17 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and mobility in wheelchair; unable to perform management of medications and treatments; was usually continent of urine; experienced impaired short-term memory and memory recall; and was at risk for falls. Negotiated service agreement and health care service plan each dated 2/22/17 documented facility services of physical assistance with bathing 3 times a week, dressing, toileting, transferring, mobility in wheelchair, and medication and treatment administration by certified staff and licensed staff.	S 195		

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 _____	07/13/2017

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 195	Continued From page 8 Record contained "Discharge of Resident" dated 6/10/17 that documented "Conditions that may result in an immediate discharge will be as follows: An infectious disease Uncontrolled behaviors endangering the health and safety of themselves, other residents. Resident's urgent medical needs require immediate transfer to another health care facility such as a hospital. Residents can be issued a 30-day discharge due to needs that cannot be met by the facility. Failure to pay the rates and charges as agreed to after reasonable notice, or the adult care home ceases to operate." The "Discharge of Resident" contained an "in conclusion" statement of "Due to un reconcilable differences between (name of facility) and (name of resident) both parties agree to discontinue services no later than the date of July 10, 2017, 30 days following the original agreed notice date of June 10, 2017." The discharge notice contained the signature of a person on the line labeled "administrator", signature of owner/operator/licensed nurse B, and signature of resident #106 with each signature dated 6/10/17. At 3:36 p.m. on 6/26/17, resident #106 confirmed he/she signed something about a 30-day notice but did not receive a copy of what he/she signed. Resident #106 asked (owner/operator/licensed nurse B) for a copy of the notice but was told the notice would be kept in (resident's) file.	S 195		

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 _____	07/13/2017

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 195	Continued From page 9 At 4:00 p.m. on 6/27/17, owner/operator/licensed nurse B stated he/she showed the discharge notice to resident and had the resident sign the notice. Owner/operator/licensed nurse B stated he/she did not give resident a copy of the notice. Owner/operator/licensed nurse B failed to provide a notice of discharge in writing to resident #106 at least 30 days before resident was discharged involuntarily.	S 195		
S 200 SS=D	26-39-102 (g) Written Discharge Notice Requirements (g) Each written transfer or discharge notice shall include the following: (1) The reason for the transfer or discharge; (2) the effective date of the transfer or discharge; (3) the address and telephone number of the complaint program of the Kansas department on aging where a complaint related to involuntary transfer or discharge can be registered; (4) the address and telephone number of the state long-term care ombudsman; and (5) for residents who have developmental disabilities or who are mentally ill, the address and telephone number of the Kansas advocacy and protection organization. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(g)(1)(3)(4)(5) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus	S 200		

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 _____	07/13/2017

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 200	Continued From page 10	S 200		

reviewed, and 4 closed records focus reviewed. Based on record review and interview for 1 (#106) of 3 residents sampled, owner/operator/licensed nurse B failed to ensure the written discharge notice included the reason for discharge; the address and telephone number of the complaint program of the Kansas department for aging and disability services where a complaint related to involuntary discharge could be registered; the address and telephone number of the state long-term care ombudsman; and for a resident with a mental illness, the address and telephone number of the Kansas advocacy and protection organization.

Findings included:

- Record review for resident #106 revealed an admission date of 2/22/17 and diagnoses of schizophrenia, major depressive disorder, and anxiety disorder.

Functional capacity screen dated 2/22/17 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and mobility in wheelchair; unable to perform management of medications and treatments; was usually continent of urine; experienced impaired short-term memory and memory recall; and was at risk for falls.

Negotiated service agreement and health care service plan each dated 2/22/17 documented facility services of physical assistance with bathing 3 times a week, dressing, toileting, transferring, mobility in wheelchair, and medication and treatment administration by certified staff and licensed staff.

Record contained "Discharge of Resident" dated

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 _____	07/13/2017

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 200	Continued From page 11 6/10/17 that documented "Conditions that may result in an immediate discharge will be as follows: An infectious disease Uncontrolled behaviors endangering the health and safety of themselves, other residents. Resident's urgent medical needs require immediate transfer to another health care facility such as a hospital. Residents can be issued a 30-day discharge due to needs that cannot be met by the facility. Failure to pay the rates and charges as agreed to after reasonable notice, or the adult care home ceases to operate." The "Discharge of Resident" contained an "in conclusion" statement of "Due to un reconcilable differences between (name of facility) and (name of resident) both parties agree to discontinue services no later than the date of July 10, 2017, 30 days following the original agreed notice date of June 10, 2017." The discharge notice contained the signature of a person on the line labeled "administrator", signature of owner/operator/licensed nurse B, and signature of resident #106 with each signature dated 6/10/17. The discharge notice did not specify the reason for resident's discharge as outlined under discharge criteria. The discharge notice lacked the address and telephone number of the complaint program of the Kansas department for aging and disability services and that a complaint related to involuntary discharge could be	S 200		

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 _____	07/13/2017

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 200	Continued From page 12 registered, lacked the address and telephone number of the state long-term care ombudsman, and the address and telephone number of the Kansas advocacy and protection organization. At 4:00 p.m. on 6/27/17, owner/operator/licensed nurse B confirmed the document "Discharge of Resident" was the 30-day discharge notice. Owner/operator/licensed nurse B failed to ensure the written discharge notice for resident #106 included the reason for discharge; the address and telephone number of the complaint program of the Kansas department for aging and disability services where a complaint related to involuntary discharge could be registered; the address and telephone number of the state long-term care ombudsman; and for a resident with a mental illness, the address and telephone number of the Kansas advocacy and protection organization.	S 200		
S5040 SS=E	26-42-101 (j) Emergency Telephone (j) Emergency telephone. Each administrator or operator shall ensure that the residents and employees have access to a telephone for emergency use at no cost. Each administrator or operator shall ensure that the names and telephone numbers of persons or places commonly required in emergencies are posted adjacent to this telephone. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(j) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus	S5040		

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 _____	07/13/2017

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
S5040	Continued From page 13 reviewed, and 4 closed records focus reviewed. Based on observation and interview for all residents, owner/operator/licensed nurse B failed to ensure the names and telephone numbers of persons or places commonly required in emergencies were posted adjacent to this telephone. Findings included: - During tour of the facility at 9:32 a.m. on 6/26/17, surveyor did not observe names and telephone numbers commonly required in an emergency posted by a telephone. At 11:58 a.m. on 6/26/17, owner/operator/licensed nurse B stated residents and staff members had access to the facility phone but the emergency numbers were not posted. Owner/operator/licensed nurse B failed to ensure the names and telephone numbers of persons or places commonly required in emergencies were posted adjacent to this telephone.	S5040		
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	S5080		

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 _____	07/13/2017

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
S5080	Continued From page 14 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(a) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on record review and interview for 1 (#107) of 4 closed records reviewed, owner/operator/licensed nurse B failed to complete the functional capacity screen according to each element and definition as specified by the department. Findings included: - Closed record review for resident #107 revealed an admission date of 11/11/16 and diagnosis of end stage dementia. Functional capacity screen dated 11/11/16 contained a score of 3 for short-term memory, 3 for long-term memory, 3 for memory recall, and 3 for decision making ability. The Resident Functional Capacity Screen Manual documents instruction to the person completing the screening to score the cognition section as "1" if resident impaired or a "0" if resident not impaired for each area of short-term memory, long-term memory, memory recall, and decision making. The	S5080		

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 _____	07/13/2017

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
S5080	Continued From page 15 manual does not give the option to use a score of "3." The Functional capacity screen lacked the signature of the person completing the screening. At 11:21 a.m. on 6/27/17, owner/operator/licensed nurse B stated he/she conducted the screening and did not know why he/she scored each section of cognition with "3" and confirmed he/she did not sign the form. For resident #107, owner/operator/licensed nurse B failed to complete the functional capacity screen according to each element and definition as specified by the department.	S5080		
S5085 SS=E	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c)(2) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on record review, observation, and interview for 3 (#104, #103, and #106) of 3 residents sampled, owner/operator/licensed	S5085		

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 _____	07/13/2017

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
S5085	Continued From page 16	S5085		

nurse B failed to conduct a screening to determine each resident's functional capacity following a significant change in condition as defined in K.A.R. 26-39-100.

Findings included:

- Record review for resident #104 revealed an admission date of 10/11/16 and diagnoses of type 2 diabetes mellitus, traumatic brain injury, paralysis, and weakness.

Functional capacity screen dated 10/11/16 indicated resident required physical assistance with bathing, dressing, toileting, and transferring.

During an interview at 2:38 p.m. on 6/27/17 resident #104 stated he/she could dress, toilet, and transfer self without physical assistance. Resident stated he/she could shower self without assistance after a staff member set up supplies for shower and supervised him/her getting in and out of shower.

At 3:11 p.m. on 6/27/17 owner/operator/licensed nurse B stated resident did require physical assistance with bathing, dressing, toileting, and transferring when admitted to the facility but now able to do these activities on own.

Owner/operator/licensed nurse B failed to conduct a screening to determine resident #104's functional capacity following a significant change in condition as defined in K.A.R. 26-39-100.

- Record review for resident #103 revealed an admission date of 5/3/17 and diagnoses of schizophrenia, epilepsy, and hypertension.

Functional capacity screen dated 5/3/17 indicated

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 _____	07/13/2017

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
S5085	Continued From page 17 resident required physical assistance with bathing and toileting. At 4:38 p.m. on 6/27/17 resident stated he/she was independent with toileting and only required stand-by assistance with getting out of shower. During time in the facility on 6/26/17 and 6/27/17 observed resident ambulate independently into and out of bathroom without need for staff assistance with toileting. Owner/operator/licensed nurse B failed to conduct a screening to determine resident #104's functional capacity following a significant change in condition as defined in K.A.R. 26-39-100. - Record review for resident #106 revealed an admission date of 2/22/17 and diagnoses of schizophrenia, major depressive disorder, and anxiety disorder. Functional capacity screen dated 2/22/17 indicated resident required physical assistance with dressing, toileting, transferring, and mobility. At 3:02 p.m. on 6/27/17 resident stated he/she was independent with dressing, toileting, transferring, and ambulation. During time in the facility on 6/26/17 and 6/27/17 observed resident independent with ambulation and that resident went in and out of bathroom without staff assisting resident to toilet. Owner/operator/licensed nurse B failed to conduct a screening to determine resident #106's functional capacity following a significant change in condition as defined in K.A.R. 26-39-100.	S5085		

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 _____	07/13/2017

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
S5105	Continued From page 18	S5105		
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 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on record review, observation, and interview for 1 (#104) of 3 residents sampled and 2 (#105 and #100) of 3 residents focus reviewed, owner/operator/licensed nurse B failed to ensure the development of a negotiated service agreement for each resident that included a description of services provided by an outside resource, the identification of the provider, and the party responsible for payment of the services. Findings included:	S5105		

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 _____	07/13/2017

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
S5105	Continued From page 19 - Record review for resident #104 revealed an admission date of 10/11/16 and diagnoses of type 2 diabetes mellitus, traumatic brain injury, paralysis, and weakness. Functional capacity screen dated 10/11/16 indicated resident was unable to perform management of medications. Negotiated service agreement dated 10/11/16 documented medication administration by certified medication aides and licensed staff. Resident's record contained a home health certification and plan of care dated 6/1/17 through 7/30/17 for a home health licensed nurse to administer insulin to resident and test blood sugar level 3 times a day. At 12:35 p.m. on 6/26/17, observed a home health nurse arrive at facility to test resident's blood sugar and administer insulin. Negotiated service agreement lacked a description of insulin administration and blood sugar testing, the name of the provider of the services, and the party responsible for payment to the outside resource. At 3:11 p.m. on 6/27/17, owner/operator/licensed nurse B confirmed the negotiated service agreement lacked a description of insulin administration and blood sugar testing, the name of the provider of the services, and the party responsible for payment to the outside resource. Owner/operator/licensed nurse B failed to ensure the development of a negotiated service agreement for resident #104 that included a	S5105		

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 _____	07/13/2017

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
S5105	Continued From page 20 description of services provided by an outside resource, the identification of the provider, and the party responsible for payment of the services. - Record review for resident #105 revealed an admission date of 11/22/16 and diagnoses of type 2 diabetes mellitus, dementia, and cardiovascular disease. Functional capacity screen dated 11/22/16 indicated resident was unable to perform management of medications and medical treatments. Negotiated service agreement dated 11/22/16 documented certified medication aides and licensed staff provided medication and treatment administration. Owner/operator/licensed nurse B documented a nurse's note entry on 5/15/17 that resident returned from a hospital stay for removal of hardware from left ankle. The entry documented the following: Presence of methicillin-resistant staphylococcus aureus in left ankle wound. Home health nurse to administer intravenous antibiotics to treat the infection and continue to administer insulin 3 times a day. Resident to receive occupational therapy and physical therapy through home health. Presence of a pressure ulcer measuring 3.5 centimeters by 3.2 centimeters on left buttock. The negotiated service agreement lacked a description of the services provided by home health and party responsible for payment for the services. Around 12:45 p.m. on 7/10/17 surveyor observed	S5105		

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 _____	07/13/2017

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
S5105	Continued From page 21	S5105		

a home health nurse in the facility propel resident in wheelchair to his/her room. Home health nurse stated he/she was going to administer insulin to resident and complete a skin assessment.

During an interview at 3:19 p.m. on 7/10/17, owner/operator/licensed nurse B stated home health nurse provided wound care, skin assessment, insulin administration, and blood sugar testing. Owner/operator/licensed nurse B stated resident had completed occupational and physical therapy Owner/operator/licensed nurse B confirmed the negotiated service agreement lacked a description of services provided by home health, the name of the licensed nurse providing the services, and the party responsible for payment for the services.

Owner/operator/licensed nurse B failed to ensure the development of a negotiated service agreement for resident #105 that included a description of services provided by an outside resource, the identification of the provider, and the party responsible for payment of the services.

- Record review for resident #100 revealed an admission date of 4/1/17 and diagnoses of type 2 diabetes mellitus.

Functional capacity screen dated 4/1/17 indicated resident was unable to perform management of medications.

Negotiated service agreement dated 4/1/17 documented certified medication aides and licensed staff administered medications to resident.

Nurse's notes contained an entry by

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 _____	07/13/2017

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
S5105	Continued From page 22 owner/operator/licensed nurse B on 5/22/17 that included documentation of home health administered insulin to resident and tested resident's blood sugar. Negotiated service agreement lacked a description of the service provided by home health and the party responsible for payment for the services. Owner/operator/licensed nurse B failed to ensure the development of a negotiated service agreement for resident #100 that included a description of services provided by an outside resource, the identification of the provider, and the party responsible for payment of the services.	S5105		
S5116 SS=E	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(2)	S5116		

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 _____	07/13/2017

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
S5116	Continued From page 23 The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on record review, observation, and interview for 2 (#104 and #106) of 3 residents sampled, owner/operator/licensed nurse B failed to revise the negotiated service agreement following a significant change in condition, as defined in K.A.R. 26-39-100; Findings included: - Record review for resident #104 revealed an admission date of 10/11/16 and diagnoses of type 2 diabetes mellitus, traumatic brain injury, paralysis, and weakness. Functional capacity screen dated 10/11/16 indicated resident required physical assistance with bathing, dressing, toileting, and transferring. Negotiated service agreement dated 10/11/16 documented services of set-up, supervision, and physical assistance with bathing; physical assistance with dressing upper body; physical assistance with mobility in wheelchair; and one-person physical assistance with transferring using a gait belt. During an interview at 2:38 p.m. on 6/27/17 resident #104 stated he/she could dress, toilet, mobilize self in wheelchair, and transfer self without physical assistance. Resident stated he/she could shower self without assistance after a staff member set up supplies for shower and supervised him/her getting in and out of shower. At 3:11 p.m. on 6/27/17 owner/operator/licensed nurse B stated resident did require physical	S5116		

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 _____	07/13/2017

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
S5116	Continued From page 24 assistance with bathing, dressing, toileting, and transferring when admitted to the facility but now able to do these activities on own. Owner/operator/licensed nurse B confirmed he/she did not revise the resident's negotiated service agreement. Owner/operator/licensed nurse B failed to revise the negotiated service agreement following a significant change in resident #104's condition, as defined in K.A.R. 26-39-100; - Record review for resident #106 revealed an admission date of 2/22/17 and diagnoses of schizophrenia, major depressive disorder, and anxiety disorder. Functional capacity screen dated 2/22/17 indicated resident required physical assistance with dressing, toileting, transferring, and mobility. Negotiated service agreement dated 2/22/17 documented services of physical assistance with dressing, toileting, transferring, and mobility using wheelchair. At 3:02 p.m. on 6/27/17 resident stated he/she was independent with dressing, toileting, transferring, and ambulation. During time in the facility on 6/26/17 and 6/27/17 observed resident independent with ambulation and that resident went in and out of bathroom without staff assisting resident to toilet. Owner/operator/licensed nurse B failed to revise the negotiated service agreement following a significant change in resident #106's condition, as defined in K.A.R. 26-39-100;	S5116		

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 _____	07/13/2017

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
S5126 SS=E	26-42-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(h) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on record review and interview for 1 (#103) of 3 residents sampled, 1 (#100) of 3 residents focus reviewed, and 1 (#107) of 4 closed records focus reviewed, owner/operator/licensed nurse B failed to ensure each person involved in the development of the negotiated service agreement signed the agreement. Findings included: - Record review for resident #103 revealed an admission date of 5/3/17 and diagnoses of schizophrenia, epilepsy, and hypertension. Resident's negotiated service agreement dated 5/3/17 contained only the signature of owner/operator/licensed nurse B. The negotiated service agreement lacked the signature of the resident as evidence resident participated in the development of the agreement. - Record review for resident #100 revealed an admission date of 4/1/17 and diagnoses of type 2	S5126		

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 _____	07/13/2017

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
S5126	Continued From page 26 diabetes mellitus. Resident's negotiated service agreement dated 4/1/17 contained only the signature of owner/operator/licensed nurse B. The negotiated service agreement lacked the signature of the resident as evidence resident participated in the development of the agreement. - Record review for resident #107 revealed an admission date of 11/11/16 and diagnosis of end stage dementia and traumatic brain injury. Resident's negotiated service agreement dated 11/11/16 contained only the signature of owner/operator/licensed nurse B. The negotiated service agreement lacked the signature of the resident's legal representative as evidence the representative participated in the development of the agreement. At 11:21 a.m. on 6/27/17, owner/operator/licensed nurse B confirmed he/she did not obtain the signature of each person participating in the development of each resident's negotiated service agreement. For residents #103, #100, and #107, owner/operator/licensed nurse B failed to ensure each person involved in the development of the negotiated service agreement signed the agreement.	S5126		
S5155 SS=D	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.	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 _____	07/13/2017

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 27	S5155		

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, 3 residents focus reviewed, and 4 closed records reviewed. Based on record review, interview, and observation for 1 (#105) of 3 residents focus reviewed, owner/operator/licensed nurse B failed to provide or coordinate the provision of necessary health care services that met the needs of the resident that were in accordance with the functional capacity screening and the negotiated service agreement.

Findings included:

- Record review for resident #105 revealed an admission date of 11/22/16 and diagnoses of type 2 diabetes mellitus, dementia, and cardiovascular disease.

Functional capacity screen dated 11/22/16 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; was unable to perform management of medications and medical treatments; was usually continent of urine; experienced impaired short-term memory and memory recall; and was at risk for falls.

Negotiated service agreement and health care service plan each dated 11/22/16 documented services of physical assistance with bathing,

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 _____	07/13/2017

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 28	S5155		

dressing, toileting every 2 hours, transferring, and mobility in wheelchair; certified medication aides and licensed staff provided medication and treatment administration.

Owner/operator/licensed nurse B documented a nurse's note entry on 5/15/17 that resident returned from a hospital stay for removal of hardware from left ankle. The entry documented the following:
Presence of methicillin-resistant staphylococcus aureus (MRSA) in left ankle wound.
Home health nurse to administer intravenous antibiotics to treat the infection and continue to administer insulin 3 times a day.
Presence of a pressure ulcer measuring 3.5 centimeters by 3.2 centimeters on left buttock.

The negotiated service agreement lacked a description of services to contain drainage from left ankle wound and to prevent the spread of MRSA bacteria to other residents; interventions to promote healing of the left ankle wound and prevent further skin breakdown; and a description of services to promote healing of the pressure ulcer and to prevent further skin breakdown due to pressure.

Around 12:45 p.m. on 7/10/17 surveyor observed a home health nurse in the facility propel resident in wheelchair to his/her room. Home health nurse stated he/she was going to administer insulin to resident and complete a skin assessment. Home health nurse confirmed resident had a stage 2 pressure ulcer [partial thickness skin loss involving epidermis, dermis, or both and presents as an abrasion or shallow crater] that was not healing and he/she had made an appointment at the wound clinic next Monday to evaluate wound. Home health nurse stated

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 _____	07/13/2017

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 29	S5155		

wound on left ankle was healed. [Note: home health services were not described in the resident's negotiated service agreement.]

Home health nurse returned to facility around 2:00 p.m. and stated when completing skin assessment earlier found an open wound on left ankle and came back with wound care supplies to clean and cover wound. Surveyor went to resident's room with home health nurse and resident. Surveyor observed a 2 to 3 centimeter open area over left lateral ankle covered with moist gray slough [dead tissue] with redness and slight swelling extending up the resident's left lateral lower leg. Home health nurse stated resident had not been able to tolerate intravenous antibiotic therapy prescribed for treatment of MRSA infection in left ankle and antibiotics had to be discontinued. Home health nurse stated unknown if MRSA still present in left ankle. Resident sat in wheelchair in his/her room while home health nurse provided wound care. Surveyor did not observe a pressure relieving mattress or overlay on the resident's hospital-type bed.

During an interview at 3:19 p.m. on 7/10/17, owner/operator/licensed nurse B stated staff wore gloves and cleaned shower with bleach when resident returned from hospital with diagnosis of MRSA infection. Owner/operator/licensed nurse stated he/she was not aware resident now had an open wound on left ankle.
Owner/operator/licensed nurse B did not provide interventions put into place to promote healing of pressure ulcer and to prevent further skin breakdown. Owner/operator/licensed nurse B stated home health takes care of pressure ulcer wound.

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 _____	07/13/2017

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 30 Owner/operator/licensed nurse B failed to provide or coordinate the provision of necessary health care services that met the needs of resident #105 that were in accordance with the functional capacity screening and the negotiated service agreement.	S5155		
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 6 residents. The sample included 3 residents, 3 residents focus review, and 4 closed records focus review. Based on record review and interview for 1 (#104) of 3 residents sampled, owner/operator/licensed nurse B failed to ensure resident received a limited concentrated sweets diet as specified in the resident's negotiated	S5185		

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 _____	07/13/2017

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
S5185	Continued From page 31 service agreement prepared according to instructions from a medical care provider or licensed dietitian. Findings included: - Record review for resident #104 revealed an admission date of 10/11/16 and diagnoses of diabetes mellitus type 2, traumatic brain injury, paralysis, and weakness. Negotiated service agreement dated 10/11/16 documented resident to receive a regular limited concentrated sweets diet. At 3:21 p.m. on 6/27/17, owner/operator/licensed nurse B stated the facility did not have written instructions from a medical care provider or licensed dietitian for staff members to follow when preparing a limited concentrated sweets diet for resident. Owner/operator/licensed nurse B failed to ensure resident #104 received a limited concentrated sweets diet as specified in the resident's negotiated service agreement prepared according to instructions from a medical care provider or licensed dietitian.	S5185		
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.	S5205		

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 _____	07/13/2017

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
S5205	Continued From page 32 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, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on interview, record review, and observation for all residents owner/operator/licensed nurse B failed to demonstrate the provision of a sufficient number of staff members to take residents who required assistance in an emergency or disaster to a secure location. Findings included: - At 10:07 a.m. on 6/26/17, owner/operator/licensed nurse B described a staffing pattern of 1 certified employee on duty on each of the 3 shifts to care for 7 residents. Resident roster documented each of the 7 residents experienced impaired cognition. At 12:00 p.m. on 6/26/17, owner/operator/licensed nurse B provided documentation dated 1/20/17 of an emergency drill with evacuation of residents. The documentation included that 4 employees participated in the drill but did not indicate how many residents lived in the facility at the time and how long it took to evacuate residents. Owner/operator/licensed nurse B stated he/she had not conducted an emergency drill with one employee evacuating residents to a safe place. Owner/operator/licensed nurse B stated the facility did not have a fire sprinkler system.	S5205		

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 _____	07/13/2017

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
S5205	Continued From page 33 During time in the facility observed residents #100, #104, and #105 each required a wheelchair for mobility. Resident #104 could self-propel wheelchair but resident's #100 and #105 required staff member to propel wheelchair. At 9:34 a.m. on 6/27/17, observed certified staff H provide physical assistance to resident #100 to transfer resident from a wheelchair to the resident's bed. At 2:30 p.m. on 6/27/17, resident #105 wanted to go outside and observed resident required physical assistance from certified staff H to get wheelchair through door and over the threshold. At 2:25 p.m. on 6/27/17 owner/operator/licensed nurse B described assistance each resident would require to exit the facility in an emergency as follows: Resident #101 required a staff member to walk resident to the exit door due to gait instability. Resident #105 required 1 staff member to transfer to wheelchair and resident could mobilize wheelchair. Resident #104 required 1 staff member to provide stand-by assistance to transfer to wheelchair and resident could mobilize wheelchair. Resident #102 usually independent with ambulation but for safety would require 1 person stand-by assistance. Resident #106 required verbal instruction to exit the facility. Resident #103 required verbal instruction to exit the facility. Resident #100 required 1 person to transfer	S5205		

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 _____	07/13/2017

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
S5205	Continued From page 34 resident to wheelchair and propel wheelchair. Owner/operator/licensed nurse B failed to demonstrate the provision of a sufficient number of staff members to take residents who required assistance in an emergency or disaster to a secure location.	S5205		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on interview for all residents and employees, owner/operator/licensed nurse B failed to demonstrate evidence of a quarterly	S5215		

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 _____	07/13/2017

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
S5215	Continued From page 35 review of the emergency management plan with employees and residents. Findings included: - At 12:04 p.m. on 6/26/17, owner/operator/licensed nurse B stated he/she had reviewed the emergency management plan with residents and employees but had not documented the review. Owner/operator/licensed nurse B could not provide dates of the review including the residents and employees present. Owner/operator/licensed nurse B failed to demonstrate evidence of a quarterly review of the emergency management plan with employees and residents.	S5215		
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.	S5230		

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 _____	07/13/2017

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
S5230	Continued From page 36 This REQUIREMENT is not met as evidenced by: KAR 26-42-207(c) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on record review and interview for 1 (#106) of 3 residents sampled and 4 of 5 employee files reviewed, the owner/operator/licensed nurse B failed to ensure the facility's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Record review for resident #106 revealed an admission date of 2/22/17 and diagnoses of major depressive disorder, schizophrenia, and anxiety disorder. The resident's record lacked documentation of a two-step tuberculosis skin test or chest x-ray to rule out presence of tuberculosis. At 4:10 p.m. on 6/27/17, owner/operator/licensed nurse B confirmed the record lacked documentation of testing for tuberculosis. - Review of employee files revealed the following: File of licensed nurse C hired 6/12/17 lacked documentation of tuberculosis testing. File of certified staff D hired 5/20/17 lacked documentation of tuberculosis testing. File of certified staff F hired 5/3/17 lacked documentation of tuberculosis testing.	S5230		

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 _____	07/13/2017

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
S5230	Continued From page 37 File of certified staff G hired 5/6/17 lacked documentation of tuberculosis testing. At 2:00 p.m. on 6/27/17 owner/operator/licensed nurse B confirmed he/she did not ensure each resident and employee received tuberculosis testing. The owner/operator/licensed nurse B failed to ensure the facility's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S5230		
S5245 SS=E	26-42-105 (b) Resident Records Confidential (b) Each administrator or operator shall ensure that all information in each resident's record, regardless of the form or storage method for the record, is kept confidential, unless release is required by any of the following: (1) Transfer of the resident to another health care facility; (2) law; (3) third-party payment contract; or (4) the resident or legal representative of the resident. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(b) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed.	S5245		

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 _____	07/13/2017

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
S5245	Continued From page 38 Based on observation, record review, and interview for all residents, owner/operator/licensed nurse B failed to ensure all information in each resident's record was kept confidential. Findings included: - Commons area of the facility was an open living area, dining area, and kitchen. At 12:07 p.m. on 6/27/17 Surveyor observed an open bookshelf with several notebooks in the living area of the commons area. The notebooks were accessible to residents and visitors. Surveyor removed each notebook and found the notebooks contained confidential resident information as follows: "Code Status Book " contained an information sheet for each of the 7 residents living in the facility. The information sheet documented resident's name, date of birth, diagnoses, social security number, Medicare #, and code status. The book contained copies of each resident's social security card, driver's license, Medicare card, and supplemental insurance card. This book also contained a copy of a social security benefit letter to resident #100 and a copy of a passport belonging to resident #102. "Lab Book" contained copies of the information sheet (as also found in the "Code Status Book") for residents #105, #104, #106, #103, #102, and #101. Notebook containing documentation of blood sugar readings for residents#104 and #105 and vital sign and weight documentation for all residents.	S5245		

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 _____	07/13/2017

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
S5245	Continued From page 39 An unlabeled notebook containing home and community based service plans and weekly care logs for 5 residents. Notebook containing home health skilled nursing documentation for resident #105 and #104. At 1:00 p.m. on 6/27/17, surveyor informed owner/operator/licensed nurse B of the confidential resident information available to anyone and owner/operator/licensed nurse B locked these notebooks in a cabinet for resident record storage. For all residents, owner/operator/licensed nurse B failed to ensure all information in each resident's record was kept confidential.	S5245		
S5250 SS=E	26-42-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition;	S5250		

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 _____	07/13/2017

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
S5250	Continued From page 40 (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(4)(6)(10) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on record review and interview for 2 (#109 and #110) of 4 closed records review, owner/operator/licensed nurse B failed to ensure each resident's record contained the functional capacity screen and negotiated service agreement. Based on record review and interview for 2 (#107 and #108) of 4 closed records reviewed, owner/operator/licensed nurse B failed to ensure each resident's record contained records of medications and treatments administered. Findings included: - Closed record review for resident #109 revealed an admission date of 11/29/16 for respite care with diagnosis of congestive heart failure. Resident documented as discharged on 12/12/16. The record lacked a functional capacity screen and a negotiated service agreement. - Closed record review for resident #110 revealed an admission date of 2/14/17 for respite care with a diagnosis of colon cancer. Resident	S5250		

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 _____	07/13/2017

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
S5250	Continued From page 41	S5250		

documented as discharged on 2/24/17. The record lacked a functional capacity screen and a negotiated service agreement.

At 1:10 p.m. on 6/27/17, owner/operator/licensed nurse B reviewed the closed records and confirmed the records each lacked the functional capacity screen and the negotiated service agreement.

For discharged residents #109 and #110, owner/operator/licensed nurse B failed to ensure each resident's record contained the functional capacity screen and negotiated service agreement.

- Closed record review for resident #107 revealed an admission date of 11/11/16, diagnosis of end stage dementia, and discharged 11/23/16. Functional capacity screen dated 11/11/16 indicated resident was unable to perform management of medications and medical treatments. Negotiated service agreement dated 11/11/16 documented service of medications and treatments administered by certified medication aide and licensed nurse. The record lacked a record of medications and treatments administered to the resident.

At 11:18 a.m. on 6/27/17, owner/operator/licensed nurse B confirmed the record lacked documentation of medications and treatments administered.

Owner/operator/licensed nurse B failed to ensure the record for resident #107 contained records of medications and treatments administered.

- Closed record review for resident #108 revealed an admission date of 12/20/16,

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 _____	07/13/2017

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
S5250	Continued From page 42 diagnosis of dementia with psychosis and type 2 diabetes mellitus, and a discharge date of 12/30/16. Functional capacity screen dated 12/20/16 indicated resident was unable to perform management of medications and medical treatments. Negotiated service agreement dated 12/20/16 documented service of medications and treatments administered by certified medication aide and licensed nurse. Record contained an admission order by a medical care provider to perform wound care to resident's left lower leg. The record lacked a record of medications and treatments administered to the resident. At 11:25 a.m. on 6/26/17, owner/operator/licensed nurse B confirmed the resident's record lacked documentation of medications and treatments administered. Owner/operator/licensed nurse B failed to ensure the record for resident #108 contained records of medications and treatments administered.	S5250		
S5251 SS=E	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, 3 residents focus	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 _____	07/13/2017

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 43	S5251		

reviewed, and 4 closed records focus reviewed. Based on record review and interview for 2 (#104 and #103) of 3 residents sampled, owner/operator/licensed nurse B failed to ensure each resident's record contained 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.

Findings included:

- Record review for resident #104 revealed an admission date of 10/11/16 and diagnoses of type 2 diabetes, traumatic brain injury, paralysis, and weakness.

Functional capacity screen dated 10/11/16 indicated resident required physical assistance with bathing, dressing, toileting, and transferring; supervision with mobility in wheelchair; unable to perform management of medications and treatments; and experienced impaired short-term memory, memory recall, and decision making. Functional capacity screen did not indicate resident was at risk for falls.

Negotiated service agreement and health care service plan each dated 10/11/16 outlined services of staff assistance with bathing, dressing, toileting, transferring, and mobility in wheelchair; at risk for falls; and medication administration by certified medication aides and licensed staff.

Review of the aide communication book [certified staff members' documentation of resident care and incidents during the 8 hour shift] revealed resident fell in bathroom while transferring self to chair on 4/26/17. Resident's record lacked

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 _____	07/13/2017

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 44	S5251		

documentation of the incident and a licensed nurse assessment of resident for injuries.

At 10:30 a.m. on 7/10/17, observed that resident #104 was not in the facility. Licensed nurse C stated resident was admitted to the hospital on 6/30/17 with diagnosis of stroke. Resident's record lacked documentation of resident's signs and symptoms and transfer to hospital on 6/30/17.

At 10:35 a.m. on 7/10/17, certified staff D stated on 6/30/17 at 1:15 p.m. resident began having difficulty moving leg and had facial drooping. Certified staff D stated he/she notified nurse (owner/operator/licensed nurse B) who instructed him/her to call 911 for resident to be transported to hospital.

Resident's record lacked documentation by owner/operator/licensed nurse B of the incident, action taken, and results of action.

On 6/26/17, owner/operator/licensed nurse B provided a copy of the resident's June 2017 medication administration record (MAR). Review of controlled medications delivered to the facility from the resident's pharmacy revealed 90 tablets of hydrocodone/acetaminophen [controlled substance for pain relief] 10/325 milligrams (mg) delivered 5/23/17 and 90 tablets delivered on 6/27/17. The June 2017 MAR contained an entry for resident to receive hydrocodone/acetaminophen 10/325 mg 1 or 2 tablets every 4 hours as needed. The June 2017 MAR lacked documentation of resident receiving any hydrocodone/acetaminophen 10/325 mg in June 2017.

Review of the original June 2017 MAR on 7/10/17

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 _____	07/13/2017

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 45	S5251		

revealed a handwritten entry for hydrocodone/acetaminophen 10/325 mg 1 tablet by mouth 3 times a day for pain at 8:00 a.m., 12:00 p.m.; and 6:00 p.m. The MAR contained some doses initialed as given and some doses blank. This entry was not on the June 2017 MAR when reviewed and copy received on 6/26/17.

At 3:34 p.m. on 7/10/17, owner/operator/licensed nurse B stated "I really don't know" when asked about the hydrocodone/acetaminophen handwritten of the June 2017 MAR that was not there on 6/26/17. Owner/operator/licensed nurse B confirmed the resident record lacked documentation of resident's fall on 4/26/17 and signs and symptoms and action taken on 6/30/17.

Owner/operator/licensed nurse B failed to ensure resident #104's record contained 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.

- Record review for resident #103 revealed an admission date of 5/3/17 and diagnoses of schizophrenia, epilepsy, and hypertension.

Functional capacity screen dated 5/3/17 indicated resident was unable to perform management of medications and experienced impaired short-term memory and memory recall.

Negotiated service agreement and health care service plan each dated 5/3/17 documented medication administration by certified staff and licensed staff.

Review of the aide communication book [certified staff members' documentation of resident care

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 _____	07/13/2017

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 46 and incidents during the 8 hour shift] revealed resident refused evening medications on 6/20/17 and morning and noon medications on 6/21/17. The June 2017 medication administration record contained initials of certified staff G on 6/20/17 that the evening medications were administered to resident and initials of certified staff F on 6/21/17 that the morning and noon medications were administered to resident. Resident's record lacked documentation of resident's refusal of medications. At 3:53 p.m. on 6/27/17, owner/operator/licensed nurse B stated resident did refuse medications and confirmed resident's record lacked documentation of this. The aide communication book contained documentation by certified staff D on first shift 6/30/17 that resident called 911 to transport to hospital because resident thought he/she was receiving narcotic medications against his/her will. Resident ' s record lacked documentation of this incident and resident's return to facility. At 3:26 p.m. on 7/10/17, owner/operator/licensed nurse stated resident went to emergency department because he/she did not want to take lorazepam (controlled substance to relieve anxiety) and wanted blood drawn for lab work. Owner/operator/licensed nurse B confirmed resident's record lacked documentation of the incident, action taken, and results of action. Owner/operator/licensed nurse B failed to ensure resident #103's record contained 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.	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 _____	07/13/2017

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
S5255 SS=E	26-42-102 (a) Staff Qualifications Sufficent Staff (a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident ' s functional capacity screening, health care service plan, and negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(a) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on record review and interview for 3 (#106, #103, and #104) of 3 residents sampled, owner/operator/licensed nurse B failed to ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident's functional capacity screening, health care service plan, and negotiated service agreement. Findings included: - Record review for resident #106 revealed an admission date of 2/22/17 and diagnoses of schizophrenia, major depressive disorder, and anxiety disorder. Functional capacity screen dated 2/22/17 indicated resident experienced impaired short term memory, memory recall, and decision-making ability.	S5255		

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 _____	07/13/2017

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
S5255	Continued From page 48 Negotiated service agreement dated 2/22/17 documented staff members to give resident 2 choices and assist resident to make decisions to address resident ' s impaired decision-making ability. Health care service plan dated 2/22/17 lacked interventions to address resident's needs related to his/her medical diagnoses of schizophrenia, major depressive disorder, and anxiety disorder. Record contained a "Discharge of resident" letter to resident dated 6/10/17 to discontinue services to resident no later than 7/10/17 due to "Un reconcilable differences" between facility and resident. At 4:00 p.m. on 6/26/17, owner/operator/licensed nurse B stated over a period of time resident ' s behavior had become more difficult to manage with resident disrespectful of staff members. Owner/operator/licensed nurse B stated resident had "exchanged words" with another resident. Owner/operator/licensed nurse B stated resident requested a cigarette every hour even though agreement with resident was a cigarette every 2 hours. Owner/operator/licensed nurse B explained resident would become upset if staff member caring for another resident and could not get resident a cigarette right away. - Record review for resident #103 revealed an admission date of 5/3/17 and diagnoses of paranoid schizophrenia, epilepsy, and hypertension. Functional capacity screen dated 5/3/17 indicated resident experienced impaired short-term memory, memory recall, and decision-making ability.	S5255		

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 _____	07/13/2017

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
S5255	Continued From page 49 Negotiated service agreement dated 5/3/17 documented resident exhibited socially inappropriate behavior with staff members and other residents. The negotiated service agreement lacked interventions to address inappropriate behaviors. Negotiated service agreement documented staff members to give resident 2 choices and assist resident to make decisions to address resident ' s impaired decision-making ability. Health care service plan dated 5/3/17 lacked interventions to address management of resident's socially inappropriate behaviors. Review of the aide communication book revealed documentation that resident refused evening medications on 6/20/17 and refused morning and lunch medications on 6/21/17. At 3:53 p.m. on 6/27/17, owner/operator/licensed nurse B stated refusal to take medications was a behavior resident exhibited. - Record review for resident #104 revealed an admission date of 10/11/16 and diagnoses of traumatic brain injury, type 2 diabetes mellitus, paralysis, and weakness. Functional capacity screen dated 10/11/16 indicated resident experienced impaired short-term memory, memory recall, and decision making. Negotiated service agreement dated 10/11/16 documented resident exhibited socially inappropriate behavior with staff members and other residents. The negotiated service agreement lacked interventions to address	S5255		

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 _____	07/13/2017

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
S5255	Continued From page 50 inappropriate behaviors. Negotiated service agreement documented staff members to give resident 2 choices and assist resident to make decisions to address resident ' s impaired decision-making ability. Health care service plan dated 10/11/17 lacked interventions to address management of resident's socially inappropriate behaviors. At 2:13 p.m. on 6/27/17, when asked for documentation of staff education to care for residents with mental illness, owner/operator/licensed nurse B stated staff members did not receive formal training. Owner/operator/licensed nurse B stated he/she told staff members what he/she had learned by caring for residents with dementia and attending some in-services regarding care of residents with mental illness. For residents #106, #103, and #104, owner/operator/licensed nurse B failed to ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident's functional capacity screening, health care service plan, and negotiated service agreement.	S5255		
S5257 SS=F	26-42-102 (c) Staff Qualifications RN available (c) A registered professional nurse shall be available to provide supervision to licensed practical nurses, pursuant to K.S.A. 65-1113 and amendments thereto. This REQUIREMENT is not met as evidenced by:	S5257		

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 _____	07/13/2017

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
S5257	Continued From page 51 KAR 26-42-102(c) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on interview and record review for all residents, owner/operator/licensed nurse B failed to ensure a registered professional nurse was available to provide supervision to the licensed practical nurse, pursuant to K.S.A. 65-1113 and amendments thereto. Findings included: - At 9:55 a.m. on 6/26/17, owner/operator/licensed nurse B stated he/she was a licensed practical nurse. At 12:10 p.m. on 6/26/17, owner/operator/licensed nurse B stated he/she hired a registered nurse on 6/12/17 and this person would be the first registered nurse (contracted or employed) for the facility since the facility opened (9/29/16). Owner/operator/licensed nurse B provided the contract signed by owner/operator/licensed nurse B and licensed nurse C signed on 6/12/17. The contract documented the registered nurse's duties as review of medical files for accuracy, answer all calls and respond immediately, assist with training staff with medical issues, report findings of internal audits to senior staff and CEO (chief executive officer), complete timesheets and turn in by the 15th and final day of each month. The contract did not specify the registered nurse would supervise licensed practical nurse. Owner/operator/licensed nurse B confirmed he/she was not supervised by a registered nurse. During a telephone interview with licensed nurse	S5257		

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 _____	07/13/2017

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
S5257	Continued From page 52 C at 8:00 p.m. on 6/27/17, surveyor asked licensed nurse C if owner/operator/licensed nurse B informed licensed nurse C he/she would be supervising the licensed practical nurse. Licensed nurse C stated "not specifically." Owner/operator/licensed nurse B failed to ensure a registered professional nurse was available to provide supervision to the licensed practical nurse, pursuant to K.S.A. 65-1113 and amendments thereto.	S5257		
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 (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.	S5258		

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 _____	07/13/2017

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
S5258	Continued From page 53 This REQUIREMENT is not met as evidenced by: KAR 26-42-102(d)(1)(2)(3) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on record review and interview for 4 of 5 employee files reviewed, owner/operator/licensed nurse B failed to ensure each file contained evidence of licensure or certification. Based on record review and interview for 1 certified employee, owner/operator/licensed nurse B failed to request a criminal background check from the department. Based on record review and interview for 3 certified employees, owner/operator/licensed nurse B failed to provide documentation that he/she contacted the Kansas nurse aide registry prior to each certified employee providing resident care that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home. Findings included: - Review of employee files revealed the following: The file of licensed nurse C hired 6/12/17 lacked documentation of contact with the Kansas state board of nursing to ensure this person had an active nursing license. The file of certified staff D hired 5/20/17 lacked proof of contact with the Kansas nurse aide registry to ensure he/she did not have a finding of having abused, neglected, or exploited a resident in an adult care home and lacked a criminal	S5258		

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 _____	07/13/2017

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
S5258	Continued From page 54 background check. The file of certified staff E hired 1/2/17 contained documentation of contact with the Kansas nurse aide registry but the form lacked a date as evidence the registry was contacted prior to staff member providing resident care in order to ensure the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home. The file of certified staff F hired 5/3/17 contained documentation of contact with the Kansas nurse aide registry but the form lacked a date as evidence the registry was contacted prior to staff member providing resident care to ensure the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home. At 2:05 p.m. on 6/27/18 owner/operator/licensed nurse B confirmed each employee file lacked all required documentation. Owner/operator/licensed nurse B failed to ensure employee files contained evidence of licensure or certification; criminal background check; and Kansas nurse aide registry verification prior to employee providing resident care.	S5258		
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	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 _____	07/13/2017

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 55 that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the 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, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on record review and interview for 3 (#104, #106, and #103) of 3 residents sampled, owner/operator/licensed nurse B failed to ensure all medications were administered to each resident in accordance with a medical care provider's written order. Findings included: - Record review for resident #104 revealed an admission date of 10/11/16 and diagnoses of traumatic brain injury and type 2 diabetes mellitus. Functional capacity screen dated 10/11/16 indicated resident was unable to perform management of medications and medical treatments.	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 _____	07/13/2017

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 56 Negotiated service agreement dated 10/11/16 documented certified medication aide or licensed nurse provided administration of medications and treatments. Comparison of the June 2017 medication administration record and the written medical care provider's orders revealed the lack of an order for the following medications certified medication aides and licensed nurse administered to resident: Calcium carbonate (supplement) 500 milligrams (mg) 2 tablets by mouth daily Vitamin D2 (supplement) 1.25 mg 1 tablet by mouth one time a week Celexa (antidepressant) 10 mg 1 tablet by mouth daily Colace (stool softener) 100 mg one capsule by mouth daily Potassium chloride (supplement)extended release 10 milliequivalents by mouth daily Glipizide (hypoglycemic) 10 mg 1 tablet by mouth two times a day Metformin (hypoglycemic) 500 mg 2 tablets by mouth 2 times a day Vitamin B-1 (supplement) 100 mg tablet 2 tablets by mouth 2 times a day Alprazolam (antianxiety) 1 mg tablet take 1/2 tablet by mouth 2 times a day Gabapentin (anticonvulsant and to treat	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 _____	07/13/2017

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 57 peripheral neuropathy) 300 mg capsule take one capsule by mouth 3 times a day Sodium chloride (supplement) 1 gram tablet take 2 tablets by mouth 4 times a day Zoloft (antidepressant) 50 mg tablet take 1 and 1/2 tablet by mouth daily Calcium carbonate 500 mg tablets 2 tablets by mouth every 4 hours as needed (reason to administer not specified) Alprazolam 1 mg tablet take 1/2 tablet by mouth every 6 hours as needed for anxiety Ibuprofen 200 mg caplet take 2 caplets by mouth every 6 hours as needed (reason to administer not specified) Fleet's enema rectally as needed for constipation Zofran 4 mg tablet 1 tablet by mouth every 6 hours as needed for nausea Milk of magnesia 30 milliliters by mouth every day as needed for constipation Bisacodyl 5 mg tablet take 2 tablets by mouth every 2 days as needed for constipation Bisacodyl 10 mg suppository insert 1 suppository rectally every 8 hours as needed for constipation Hydrocodone/acetaminophen 7.5/325 mg tablet take one or two tablets by mouth every 4 hours as needed for pain At 3:21 p.m. on 6/27/17, owner/operator/licensed nurse B stated he/she did not receive medical	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 _____	07/13/2017

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 58	S5300		

care provider's written orders for these medications. Owner/operator/licensed nurse B stated resident was admitted to this facility from another facility and he/she entered medications on medication administration record as recorded on the copy of the medication administration record sent from previous facility.

Owner/operator/licensed nurse B failed to ensure all medications were administered to resident #104 in accordance with a medical care provider's written order.

- Record review for resident #106 revealed an admission date of 2/22/17 and diagnoses of major depressive disorder, schizophrenia, anxiety disorder, and hypothyroidism.

Functional capacity screen dated 2/22/17 indicated resident was unable to perform management of medications and medical treatments.

Negotiated service agreement dated 2/22/17 documented service of facility management of medications and treatments.

Comparison of the June 2017 medication administration record and the written medical care provider's orders revealed the lack of an order for the following medications certified medication aides and licensed nurse administered to resident:

Levothyroxine (to treat hypothyroidism) 0.05 milligram (mg) tablet 1 tablet by mouth daily

Anoro ellipta 62.5/25 micrograms inhale 1 puff by mouth once daily for allergic rhinitis

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 _____	07/13/2017

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 59 Lisinopril 40 mg tablet one tablet daily by mouth for hypertension Cymbalta 60 mg capsule take one capsule along with 30 mg capsule to equal 90 mg total daily by mouth for depression Vitamin D2 (supplement) 1.25 mg capsule take one capsule by mouth one time a week Plavix (blood thinner) 75 mg tablet one tablet daily by mouth Zyrtec 10 mg tablet one tablet by mouth daily for allergic rhinitis Oxycodone/acetaminophen (pain relief) 10/325 mg tablet one tablet by mouth 3 times a day Gabapentin 300 mg capsule take one capsule by mouth 3 times a day for neuropathy Baclofen (muscle relaxant) 10 mg tablet take one tablet by mouth 3 times a day Norvasc (anti-hypertensive) 5 mg tablet take one tablet by mouth daily Ambien (sleep aid) 5 mg tablet take one tablet by mouth at bedtime Oxycodone/acetaminophen 10/325 mg tablet take one tablet by mouth as needed Ibuprofen (anti-inflammatory) 200 mg 1 tablet by mouth every 6 hours as needed Zofran 4 mg tablet take 1 tablet by mouth every 6 hours as needed for nausea/vomiting	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 _____	07/13/2017

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 60 Colace (stool softener) 100 mg capsule take one capsule every 12 hours as needed for constipation At 4:10 p.m. on 6/27/17, owner/operator/licensed nurse B stated he/she followed medications listed on the copy of the medication administration record from the facility resident lived in prior to admission at this facility. Owner/operator/licensed nurse B confirmed the lack of a written medical care provider's order to administer medications as listed. Owner/operator/licensed nurse B failed to ensure all medications were administered to resident #106 in accordance with a medical care provider's written order. - Record review for resident #103 revealed an admission date of 5/3/17 and diagnoses of schizophrenia, epilepsy, and hypertension. Functional capacity screen dated 5/3/17 indicated resident was unable to perform management of medications and medical treatments. Negotiated service agreement dated 5/3/17 documented certified medication aide and licensed nurse to administer medications and treatments. Comparison of the June 2017 medication administration record and the written medical care provider's orders revealed the lack of an order for the following medications certified medication aides and licensed nurse administered to resident:	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 _____	07/13/2017

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 61 Fosamax (treatment of osteoporosis) 70 milligrams (mg) tablet take 1 tablet by mouth 1 time a week Zyprexa (to treat schizophrenia) 5 mg tablet take 1 tablet by mouth daily Abilify (to treat schizophrenia) 20 mg tablet take 1 tablet by mouth daily Lorazepam 1 mg tablet take 1/2 tablet by mouth 2 times a day for anxiety Acetaminophen 325 mg tablets take 2 tablets by mouth 2 times a day for pain Vimpat (anticonvulsant) 100 mg tablet take one tablet by mouth 2 times a day Keppra (anticonvulsant) 1,000 mg tablet take 1 and 1/2 tablet by mouth 2 times a day Lamictal (anticonvulsant) 25 mg tablet take 2 tablets by mouth 2 times a day Lamictal 200 mg tablet take 1 tablet by mouth 2 times a day Sinemet (treatment of Parkinson's disease) 25/100 mg tablet take 1 and 1/2 tablet by mouth 3 times a day Calcium 600 mg with vitamin D 400 mg tablet take 1 tablet 3 times a day for supplement Gabapentin (anticonvulsant) 100 mg capsule take one capsule by mouth 3 times a day Sennokot-S (laxative) 8.6/50 mg tablet take 2 tablets by mouth at bedtime daily Colace 100 mg capsule take one capsule by	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 _____	07/13/2017

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 62 mouth 2 times a day as needed for constipation Lorazepam 1 mg tablet take 1/2 tablet by mouth every 6 hours as needed for anxiety Acetaminophen 325 mg tablet take 2 tablets by mouth every 6 hours as needed Robitussin DM cough syrup give 10 milliliter (ml) by mouth every 6 hours as needed for cough Milk of magnesia 30 ml by mouth every day as needed for constipation Diazepam 10 mg/ml intramuscular injection of 5 mg as needed for seizure lasting longer than 2 minutes. At 3:47 p.m. on 6/27/17, owner/operator/licensed nurse B stated resident transferred here from another facility and sent a medication list with resident. Owner/operator/licensed nurse B stated he/she followed this list for medications to administer to resident. Owner/operator/licensed nurse B failed to ensure all medications were administered to resident #103 in accordance with a medical care provider's written order.	S5300		
S5315 SS=F	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations.	S5315		

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 _____	07/13/2017

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
S5315	Continued From page 63 (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h)(1) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on observation, interview, and record review for all residents, owner/operator/ licensed nurse B failed to ensure all medications were securely and properly stored in accordance with federal and state laws and regulations within a	S5315		

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 _____	07/13/2017

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
S5315	Continued From page 64	S5315		

locked medication cart; all controlled medications were stored in a separately locked compartment within a locked medication cart or refrigerator; and that only licensed nurses and medication aides had access to the stored medications.

Findings included:

- At 9:38 a.m. on 6/26/17, surveyor observed a medication cart located by the back door in the dining area. Surveyor observed a key in the lock of the medication cart and that the cart was unlocked. Surveyor opened the top two drawers of the cart and observed medications belonging to residents. Certified staff D walked to the medication cart confirmed he/she had left the cart unlocked and the keys in the lock, and that he/she was a certified medication aide (CMA). Certified staff D stated the key ring held the key to unlock the storage compartment containing controlled medications within the medication cart. Surveyor asked to see the contents of the controlled medication compartment. Certified staff D stated he/she discovered discrepancies with amount of controlled medications when he/she prepared morning medications for residents. Certified staff D explained that he/she did not count controlled medications at shift change with the person working 10:00 p.m. to 6:00 a.m. shift because that person was a certified nurse aide (CNA) and not a CMA.

Owner/operator/licensed nurse B arrived at the facility at 9:55 a.m. on 6/26/17. At 10:07 a.m. owner/operator /licensed nurse B described a staffing pattern of one CMA on duty from 6:00 a.m. until 2:00 p.m., one CNA on duty 2:00 p.m. until 10:00 p.m., and one CNA on duty from 10:00 p.m. until 6:00 a.m. Owner/operator/licensed nurse B stated he/she or a CMA came to the

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 _____	07/13/2017

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
S5315	Continued From page 65 facility to pass 6:00 p.m. and 9:00 p.m. medications to residents and during the 10:00 p.m. to 6:00 a.m. shift only if a resident needed a medication on an as needed basis. Owner/operator/licensed nurse B stated that the CMA placed the medication cart keys in a locked kitchen cabinet when he/she went off duty. Owner/operator/licensed nurse B stated CNAs had the key to unlock the kitchen cabinet that held the medication cart keys. At 10:56 a.m. on 6/26/17, owner/operator/licensed nurse B used a key on the medication cart key ring to unlock the medication refrigerator located on the kitchen counter top. Surveyor observed the following controlled medications in the refrigerator that were not in a separately locked compartment: Resident #107 (discharged 11/23/16) Lorazepam (antianxiety medication) liquid 1 milligram (mg) per milliliter (ml) 16 ml remaining in one bottle and 8 ml remaining in second bottle. Three syringes filled with 1 ml of Lorazepam topical 1 mg per ml. Liquid morphine (pain medication) 40 mg per ml with 10 ml remaining in one bottle and 6 ml remaining in second bottle. Resident #110 (discharged 2/24/17) Morphine liquid 40 mg per ml with 10 ml remaining. Lorazepam liquid 1mg per ml with 8 ml remaining. Resident #109 (discharged 12/12/16) Lorazepam liquid 1 mg per ml with 11 ml remaining. Morphine liquid 40 mg per ml with 4 ml remaining.	S5315		

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 _____	07/13/2017

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
S5315	Continued From page 66 Resident #105 (current resident) Lorazepam topical 1 mg per 1 ml 28 pre-filled 1 ml syringes. The resident roster documented the facility managed medications for all residents. At 12:35 p.m. on 6/26/17, surveyor observed a home health nurse walk to the medication cart in the dining area, open the top drawer of the cart, and remove an insulin pen. The medication cart was unlocked. Certified staff D was in another room of the facility. Owner/operator/licensed nurse B confirmed certified staff D left the medication cart unlocked and unattended. At 3:36 p.m. on 6/26/17, observed resident #106 ask certified staff E (CNA) for a cigarette. Certified staff E went to find owner/operator/licensed nurse B in another room of the facility and came back with the keys to the medication cart. Certified staff E unlocked the cart, gave resident #106 a cigarette, and placed the keys on top of the medication cart. At 3:55 p.m. on 6/26/17, owner/operator/licensed nurse B stated he/she moved resident #106's cigarettes to a locked drawer in the kitchen since CNAs were not to have access to the medication cart. Owner/operator/licensed nurse B confirmed resident's cigarettes had always been stored in the medication cart and that CNAs had access to the medication cart. On 7/10/17 at 1:45 p.m. owner/operator/licensed nurse B removed 2 syringes of valium labeled as 10 milligrams per 2 milliliters with name of resident #103. Surveyor observed these syringes were not locked in the controlled substance locked area within the medication cart.	S5315		

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 _____	07/13/2017

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
S5315	Continued From page 67 During a phone interview at 11:16 a.m. on 7/12/17, certified staff G stated sometimes a certified nurse aide worked the shift before certified staff G and he/she would find the keys to the medication cart on top of the cart. For all residents, owner/operator/ licensed nurse B failed to ensure all medications were securely and properly stored in accordance with federal and state laws and regulations within a locked medication cart; all controlled medications were stored in a separately locked compartment within a locked medication cart or refrigerator; and that only licensed nurses and medication aides had access to the stored medications.	S5315		
S5316 SS=F	26-42-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist;	S5316		

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 _____	07/13/2017

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
S5316	Continued From page 68 or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(i) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records focus reviewed. Based on interview, observation, and record review for 3 (#104, #106, and #103) of 3 residents sampled, 3 (#101, #100, and #105) focus reviewed residents and 3 (#107, #110, and #109) of 4 closed records focus reviewed, owner/operator/licensed nurse B failed to ensure records were maintained for the receipt and disposition of controlled medications in sufficient detail for an accurate reconciliation and further failed to follow facility's policy and procedure to ensure accurate count of controlled medications at each shift change. Findings included: - At 9:38 a.m. on 6/26/17, surveyor observed a medication cart located by the back door in the dining area. Surveyor observed a key in the lock of the medication cart and that the cart was unlocked. Surveyor opened the top two drawers of the cart and observed medications belonging to residents. Certified staff D walked to the medication cart, confirmed he/she had left the	S5316		

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 _____	07/13/2017

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
S5316	Continued From page 69	S5316		

cart unlocked and the keys in the lock, and that he/she was a certified medication aide (CMA). Certified staff D stated the key ring held the key to unlock the storage compartment containing controlled medications within the medication cart. Surveyor asked to see the contents of the controlled medication compartment. Certified staff D stated he/she discovered discrepancies with amount of controlled medications when he/she prepared morning medications for residents. Certified staff D explained that he/she did not count controlled medications at shift change with the person working 10:00 p.m. to 6:00 a.m. shift because that person was a certified nurse aide (CNA) and not a CMA. Certified staff D stated he/she last worked the 6:00 a.m. to 2:00 p.m. shift on Friday (6/23/17) and counted the amount of controlled medications on hand with owner/operator/licensed nurse B. Certified staff D stated the count sheet for each controlled medication and the amount of medication on hand were accurate at that time. Certified staff D stated he/she called owner/operator/licensed nurse B this morning when he/she discovered the discrepancies.

Owner/operator/licensed nurse B arrived at the facility at 9:55 a.m. on 6/26/17 and stated certified staff G had worked as the CMA Saturday (6/24/17) and Sunday (6/25/17) and needed "to come in and fix the book" (the controlled medication count sheets).

At 10:15 a.m. on 6/26/17 along with owner/operator/licensed nurse B compared the amount of controlled medications on hand for residents with the sign out sheet ("Individual Residents Controlled Substance Record") for each medication and found the following

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 _____	07/13/2017

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
S5316	Continued From page 70 discrepancies: Resident #101 Hydrocodone/acetaminophen (pain relief) 10/325 milligrams (mg) sign out sheet for the 8:00 a.m. dose recorded 27 tablets remained after one tablet removed at 8:00 a.m. on 6/11/17 by certified staff G and 25 tablets remained after one tablet removed at 8:00 a.m. on 6/12/17 by certified staff D. On 6/25/17 certified staff G documented 11 tablets remained after removal of 1 tablet at 8:00 a.m. and on 6/26/17 certified staff D documented 9 tablets remained after removal of 1 tablet at 8:00 a.m. The 8:00 a.m. card of hydrocodone/acetaminophen 10/325 mg held 9 tablets. Two tablets short. Hydrocodone/acetaminophen 5/325 mg sign out sheet for the PRN (as needed) dose recorded 16 tablets remained at 12:00 p.m. on 4/5/17 as the last dose resident received from this medication package and surveyor observed 15 tablets remained in the medication package. One tablet short. Resident #104 Alprazolam (antianxiety) 0.5 mg sign out sheet for 8:00 a.m. dose recorded 8 tablets remained after one tablet removed by certified staff D at 8:00 a.m. on 6/26/17. Surveyor observed 9 tablets remained in the medication package. One more tablet on hand than recorded on sign out sheet. Ambien (sleep aid) 10 mg sign out sheet recorded 4 tablets remained after one tablet removed by certified staff G at 8:00 p.m. on 6/24/17. Certified staff G made two entries with date of 6/24/17 signing out for one tablet each entry. The sign out sheet lacked an entry for 8:00 p.m. 6/25/17. Surveyor observed 3 tablets	S5316		

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 _____	07/13/2017

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
S5316	Continued From page 71 remained in the medication package. One tablet short. Hydrocodone/acetaminophen 10/325 mg sign out sheet for PRN (as needed) medication package documented 28 tablets remained and observed 27 tablets remained in medication package. One tablet short. Alprazolam 0.5 mg sign out sheet labeled "afternoon" recorded 30 tablets remained and observed 29 tablets in medication package. One tablet short. Resident #106 Oxycodone/acetaminophen (pain relief) 10/325 mg Sign out sheet for morning dose recorded 4 tablets remained and observed 5 tablets remained in medication package. One more tablet on hand than recorded on sign out sheet. Oxycodone/acetaminophen 10/325 mg sign out sheet for evening dose recorded 5 tablets remained and observed 4 tablets in medication package. One tablet short. Lorazepam (antianxiety) 2 mg tablet sign out sheet for morning dose recorded 12 tablets remained and observed 13 tablets remained in medication package. One more tablet on hand than recorded on sign out sheet. Lorazepam 2 mg tablet sign out sheet for bedtime dose recorded 29 tablets remained and observed 23 tablets in medication package. Six tablets short. Ambien 5 mg sign out sheet recorded 5 tablets remained and observed 4 tablets in medication package. One tablet short.	S5316		

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 _____	07/13/2017

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
S5316	Continued From page 72 Resident #100 Hydrocodone/acetaminophen 5/325 sign out sheet for morning dose recorded 6 tablets remained and observed 7 tablets in medication package. One more tablet on hand than recorded on sign out sheet. Hydrocodone/acetaminophen 5/325 sign out sheet for noon dose recorded 7 tablets remained and observed 8 tablets in medication package. One more tablet on hand than recorded on sign out sheet. Hydrocodone/acetaminophen 5/325 sign out sheet for evening dose recorded 7 tablets remained and observed 6 tablets in medication package. One tablet short. Resident #105 Lorazepam 0.5 mg sign out sheet for morning dose recorded 4 tablets remained and observed 2 tablets in medication package. Two tablets short. Lorazepam 0.5 mg medication package with 25 tablets lacked a sign out sheet. At 10:56 a.m. on 6/26/17, owner/operator/licensed nurse B used a key on the medication cart key ring to unlock the medication refrigerator located on the kitchen counter top. Surveyor observed the following controlled medications in the refrigerator for discharged residents: Resident #107 (discharged 11/23/16) Lorazepam (antianxiety medication) liquid 1 milligram (mg) per milliliter (ml) 16 ml remaining in one bottle and 8 ml remaining in second bottle.	S5316		

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 _____	07/13/2017

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
S5316	Continued From page 73 Three syringes filled with 1 ml of Lorazepam topical 1 mg per ml. Liquid morphine (pain medication) 40 mg per ml with 10 ml remaining in one bottle and 6 ml remaining in second bottle. Each medication lacked a sign out sheet. Resident #110 (discharged 2/24/17) Morphine liquid 40 mg per ml with 10 ml remaining. Lorazepam liquid 1mg per ml with 8 ml remaining. Each medication lacked a sign out sheet. Resident #109 (discharged 12/12/16) Lorazepam liquid 1 mg per ml with 11 ml remaining. Morphine liquid 40 mg per ml with 4 ml remaining. Each medication lacked a sign out sheet. At 11:15 a.m. on 6/26/17, owner/operator/licensed nurse B stated he/she removed the sign out sheets for these controlled medications and stored off-site with each resident's closed record. Owner/operator/licensed nurse B stated he/she came to the facility daily to count controlled medications with the CMA but did not do this on 6/24/17 and 6/25/17. Owner/operator/licensed nurse B confirmed he/she and CMA did not document when they compared the amount of medication recorded on the sign out sheet with the amount of the medication on hand and that	S5316		

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 _____	07/13/2017

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
S5316	Continued From page 74 the reconciliation was accurate. On 7/10/17 at 1:45 p.m. owner/operator/licensed nurse B removed 2 syringes of valium labeled as 10 milligrams per 2 milliliters with name of resident #103 from a drawer in the medication cart. Surveyor did not observe a controlled substance sign out sheet for the syringes of valium. Facility's medication administration policy and procedure documented "All narcotics [controlled medications] must be counted for all shifts and signed by on-coming staff that count is correct." During a phone interview at 11:16 a.m. on 7/12/17, certified staff G stated he/she had never counted controlled medications with another certified medication aide or nurse at the start of his/her shift. Owner/operator/licensed nurse B failed to ensure records were maintained for the receipt and disposition of controlled medications in sufficient detail for an accurate reconciliation and further failed to follow facility's policy and procedure to ensure accurate count of controlled medications at each shift change.	S5316		
S5325 SS=D	26-42-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist or licensed nurse shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the home and each time the resident experiences any significant change in condition.	S5325		

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 _____	07/13/2017

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
S5325	Continued From page 75 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(l) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records reviewed. Based on record review and interview for 1 (#104) of 3 residents sampled, owner/operator/licensed nurse B failed to ensure a licensed pharmacist or licensed nurse conducted a medication regimen review at least quarterly for the resident whose medication was managed by the facility. Findings included: - Record review for resident #104 revealed an admission date of 10/11/16 and diagnoses of traumatic brain injury and type 2 diabetes mellitus. Functional capacity screen dated 10/11/16 indicated resident was unable to perform management of medications and medical treatments. Negotiated service agreement dated 10/11/16 documented certified medication aide or licensed nurse provided administration of medications and treatments. Record contained a medication regimen review by a licensed pharmacist dated 3/12/17 and 6/13/17. The record lacked documentation of a quarterly medication regimen review prior to 3/12/17.	S5325		

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 _____	07/13/2017

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
S5325	Continued From page 76 At 3:30 p.m. on 6/27/17, owner/operator/licensed nurse B stated 3/12/17 was the first time a pharmacist came to facility to complete a medication regimen review. Owner/operator/licensed nurse B failed to ensure a licensed pharmacist or licensed nurse conducted a medication regimen review at least quarterly for resident #104 whose medication was managed by the facility.	S5325		
S5327 SS=D	26-42-205 (l) (2) Medication Regimen Review Variance Report (l) (2) The licensed pharmacist or licensed nurse shall notify the medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist shall notify a licensed nurse within 48 hours of any variance identified in the resident ' s regimen review that does not require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident ' s medical care provider. The licensed nurse shall seek a response from the medical care provider within five working days of the medical care provider ' s notification of a variance. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(l)(2) The facility reported a census of 7 residents. The sample included 3 residents, 3 residents focus reviewed, and 4 closed records reviewed. Based	S5327		

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 _____	07/13/2017

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
S5327	Continued From page 77 on record review and interview for 1 (#104) of 3 residents sampled, owner/operator/licensed nurse B failed to notify the resident's medical care provider of a variance identified by a licensed pharmacist in the medication regimen review. Findings included: - Record review for resident #104 revealed an admission date of 10/11/16 and diagnoses of traumatic brain injury and type 2 diabetes mellitus. Functional capacity screen dated 10/11/16 indicated resident was unable to perform management of medications and medical treatments. Negotiated service agreement dated 10/11/16 documented certified medication aide or licensed nurse provided administration of medications and treatments. Record contained a medication regimen review by a licensed pharmacist dated 6/13/17 that indicated medical care provider to be consulted regarding a dose reduction for Xanax (antianxiety medication). The record lacked documentation that the medical care provider was notified of this request by the licensed pharmacist. At 3:30 p.m. on 6/27/17, owner/operator/licensed nurse B stated he/she was not aware of the pharmacist's recommendation and had not contacted medical care provider. Owner/operator/licensed nurse B failed to notify the medical care provider for resident #104 of a variance identified by a licensed pharmacist in the medication regimen review.	S5327		

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 _____	07/13/2017

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