STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087216	A. BUILDING: _____ B. WING _____	06/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BOOMERS HOME PLUS, LLC	6953 E KENTFORD CIRCLE WICHITA, KS 67226

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for investigation of complaint #116936 and facility report #116524 of the above home plus facility on 6/13/17, 6/14/17, 6/15/17, and 6/19/17.	S 000		
S 100 SS=D	26-39-103 (a) RESIDENT RIGHTS a) Protection and promotion of resident rights. Each administrator or operator shall ensure the protection and promotion of the rights of each resident as set forth in this regulation. Each resident shall have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the adult care home. This STANDARD is not met as evidenced by: KAR 26-39-103(a) The facility reported a census of 5 residents. The sample included 2 residents and 1 closed record reviewed. Based on record review and interview for 1 (#6) of 1 closed record reviewed, the operator failed to ensure the resident had the right to a dignified existence and self-determination. Findings included: - Record review for resident #6 revealed an admission date of 8/31/16 and diagnoses of cerebrovascular accident and type 2 diabetes mellitus. Functional capacity screen dated 12/28/16 indicated resident did not have impaired cognition	S 100		

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

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S 100	Continued From page 1	S 100		

and was independent with mobility in wheelchair; required supervision with transferring; physical assistance with bathing, dressing, and toileting; was at risk for falls; exhibited socially inappropriate behaviors; and resident's speech was sometimes understandable.

Negotiated service agreement/health care service plan dated 12/28/16 documented staff members to supervise resident with transferring, independent with mobility with wheelchair, monitor and report behaviors, resident to call for assistance due to risk for falls, no added salt diet, may have whatever sweets (resident) wants, and limited fluids after 8:00 p.m. Negotiated service agreement/health care service plan documented resident communicated by using hand gestures, shaking/nodding head, and occasional grunting sound.

Negotiated service agreement documented "Behavior Plan in place for inappropriate behaviors towards staff." Health care service plan documented "Behavior plan due to inappropriate behavior toward staff." Record contained a form "Behavior Intervention Plan" dated 9/21/16 and signed by licensed nurse K that documented the following:

Challenging behavior: Resident pulled down a staff member's article of clothing.

Desired behavior (goal): To not have any more incidents of this behavior.

Interventions: Meeting with resident and guardian about behavior. Staff training.

Consequence management: Resident and guardian were notified that another incident will

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S 100	Continued From page 2 result in eviction. Monitoring: Staff to report any and all incidents to operator and nurse immediately. The negotiated service agreement lacked interventions for staff members to appropriately manage resident's inappropriate behaviors without the threat of eviction. During an interview at 4:23 p.m. on 6/13/17, licensed nurse B stated resident received Geodon (an antipsychotic medication) when asked for the interventions staff members implemented to manage the resident's behaviors. The negotiated service agreement documented "Limit fluid intake after 8:00 p.m." The health care service plan instructed staff members to limit fluids after 8:00 p.m. (Note: the negotiated service agreement and the health care service plan did not prohibit fluids after 8:00 p.m.) During an interview at 10:35 a.m. on 6/14/17, licensed nurse B stated this intervention was in place for the resident when he/she started to work in March 2017 and stated likely due to resident's excessive urination at night. Licensed nurse B confirmed the lack of a medical care provider's order for this. Negotiated service agreement/health care service plan documented resident could have whatever sweets he/she wanted to eat. Medical care provider ordered a no added salt diet that did not limit resident's carbohydrate intake. Review of documentation by certified staff members revealed the following:	S 100		

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S 100	Continued From page 3 5/18/17 6:00 a.m. to 2:00 p.m. shift certified staff J documented resident got upset when could not have more cereal. 5/18/17 2:00 p.m. to 10:00 p.m. shift certified staff C documented resident got into brownies without permission. At evening meal resident wanted 2 slices of bread but only gave resident one slice. Resident threw that slice of bread and tried to go out front door. 5/21/17 2:00 p.m. to 10:00 p.m. shift certified staff C documented resident got mad when staff member would not give him/her more tea to drink. 5/22/17 2:00 p.m. to 10:00 p.m. certified staff G documented resident wanted more fluids around 9:50 p.m. and staff member told resident he/she could not have fluids after 8:00 p.m. (Note: negotiated service agreement/health care service plan documented limited fluids after 8:00 p.m. not that fluids were prohibited.) 5/22/17 10:00 p.m. to 5/23/17 6:00 a.m. certified staff G documented resident "was an elopement risk" at 1:00 a.m. and had previously been denied fluids because of care plan. Resident exited through front door and explained to resident he/she could go out on patio in backyard. Resident got upset, went to room and got jacket and hat and proceeded to go outside. Certified staff G documented "tried my best to bring (resident) back inside but (resident) was forceful and resisted and ended up falling out of wheelchair." Certified staff G assisted resident back into wheelchair with resident still upset and wanting to leave. Facility operator and licensed nurse B notified. Interdisciplinary progress notes contained	S 100		

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S 100	Continued From page 4	S 100		

documentation by licensed nurse B dated 5/23/17 (no time of entry documented) that certified staff G called the nurse to report resident at approximately 1:00 a.m. went to front door of facility and attempted to leave. Certified staff G met resident at door in attempt to stop resident from leaving but then went to get phone to call facility operator E and resident went out the door in wheelchair. Certified staff G met resident in driveway and resident resisted when certified staff G attempted to assist resident back into facility. Resident stood up from wheelchair and fell forward causing injury to face, right forearm, and abrasions to knees. Resident was transported by ambulance to hospital emergency department for evaluation and then returned to facility. Upon return to facility resident upset with nursing staff and became increasingly agitated pushing staff and yelling curse words. Medical care provider updated and received order for Geodon (antipsychotic) 20 milligrams intramuscularly now and Geodon 20 milligrams by mouth daily.

During an interview at 4:00 p.m. on 6/14/17, certified staff D stated he/she allowed resident to have dessert at mealtime but had been instructed by (operator E) to not allow resident to have whatever the resident found in the kitchen as a snack without checking resident's blood sugar first. Certified staff D stated resident would become agitated when told blood sugar had to be tested prior to allowing resident to have whatever snack he/she wanted.

At 4:12 p.m. on 6/14/17, certified staff C stated (operator E) told him/her to not allow resident to have sweets. Certified staff C stated he/she had not received any instruction from a licensed nurse regarding not allowing sweets, limiting fluids, or interventions to manage resident's behaviors.

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S 100	Continued From page 5 Certified staff C stated resident's behaviors started when not allowed to have what resident wanted to eat or drink. The operator failed to ensure resident #6 had the right to a dignified existence and self-determination.	S 100		
S 195 SS=D	26-39-102 (f) Discharge Notice (f) The administrator or operator, or the designee, shall provide a notice of transfer or discharge in writing to the resident or resident ' s legal representative at least 30 days before the resident is transferred or discharged involuntarily, unless one of the following conditions is met: (1) The safety of other individuals in the adult care home would be endangered. (2) The resident's urgent medical needs require an immediate transfer to another health care facility. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(f) The facility reported a census of 5 residents. The sample included 2 residents and 1 closed record reviewed. Based on record review and interview for 1 (#6) of 1 closed record reviewed, the operator failed to provide a notice of discharge in writing to the resident or resident's legal representative at least 30 days before the resident would be discharged involuntarily, Findings included:	S 195		

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S 195	Continued From page 6 - Record review for resident #6 revealed an admission date of 8/31/16 and diagnoses of cerebrovascular accident and type 2 diabetes mellitus. Functional capacity screen dated 12/28/16 indicated resident did not have impaired cognition, was independent with mobility in wheelchair, and exhibited socially inappropriate behaviors. Negotiated service agreement/health care service plan documented staff to monitor and report behaviors and behavior plan due to inappropriate behavior toward staff. Record contained a behavior intervention plan dated 9/21/16 that resident and guardian informed if resident had incidents of inappropriate behavior directed toward staff members the resident would be evicted from the facility. The intervention plan lacked direction to staff members of interventions to implement to manage resident behavior. Record contained documentation by licensed nurse B dated 5/23/17 (no time of entry documented) that certified staff G called the nurse to report resident at approximately 1:00 a.m. went to front door of facility and attempted to leave. Certified staff G met resident at door in attempt to stop resident from leaving but then went to get phone to call facility operator E and resident went out the door in wheelchair. Certified staff G met resident in driveway and resident resisted when certified staff G attempted to assist resident back into facility. Resident stood up from wheelchair and fell forward causing injury to face, right forearm, and abrasions to knees. Resident was transported by ambulance to hospital emergency department for evaluation and then returned to facility. Record contained a "30 day notice to discharge" the resident dated 6/1/16 that as of 5/24/17	S 195		

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S 195	Continued From page 7 (resident) to be discharged by 6/24/17 due to inability to meet resident's needs. The notice documented resident was at risk for elopement and "we are not a secure or lock down facility." Resident's guardian signed receipt of written notice on 6/1/17. At 4:30 p.m. on 6/14/17, operator F stated he/she used a discharge notice form letter on the computer and forgot to change date from 6/1/16. Operator F confirmed resident's guardian received the notice on 6/1/17 and notice instructed discharge of resident by 6/24/17. The operator failed to provide a notice of discharge in writing to resident #6 or resident's legal representative at least 30 days before the resident would be discharged involuntarily,	S 195		
S5028 SS=D	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if	S5028		

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S5028	Continued From page 8 the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(3)(A)(C)(E) The facility reported a census of 5 residents. The sample included 2 residents and 1 closed record reviewed. Based on record review and interview for 1 (#6) of 1 closed record reviewed, the operator failed to report an allegation of potential abuse and/or neglect to the department within 24 hours of the incident, failed to conduct a thorough investigation within 5 working days, and failed to submit the completed investigation report to the department within 5 working days of the initial report. Findings included: - On 5/31/17 the department received an e-mail from the facility reporting that on 5/23/17 resident #6 "eloped" from the facility and experienced a fall with injuries. The e-mail documented resident went to front door of facility and a certified staff member tried to stop resident at the door but left the resident to get the phone to call the facility operator. Resident went out the door. Certified staff then went outside to the resident who was half-way down driveway and operator told	S5028		

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S5028	Continued From page 9	S5028		

certified staff member to not allow resident to go any further. Certified staff member took hold of wheelchair, resident stood up and fell receiving abrasion to face with bruising, abrasions to knees, and right arm.

Record review for resident #6 revealed an admission date of 8/31/16 and diagnoses of cerebrovascular accident and type 2 diabetes mellitus..

Functional capacity screen dated 12/28/16 indicated resident did not have impaired cognition and was independent with mobility in wheelchair; required supervision with transferring; physical assistance with bathing, dressing, and toileting; was at risk for falls; exhibited socially inappropriate behaviors; and resident's speech was sometimes understandable.

Negotiated service agreement/health care service plan dated 12/28/16 documented staff members to supervise resident with transferring, independent with mobility with wheelchair, monitor and report behaviors, resident to call for assistance due to risk for falls, no added salt diet, may whatever sweets (resident) wants, and limited fluids after 8:00 p.m. Negotiated service agreement/health care service plan documented resident communicated by using hand gestures, shaking/nodding head, and occasional grunting sound.

Interdisciplinary progress notes contained documentation by licensed nurse B dated 5/23/17 (no time of entry documented) that certified staff G called the nurse to report resident at approximately 1:00 a.m. went to front door of facility and attempted to leave. Certified staff G met resident at door in attempt to stop resident

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S5028	Continued From page 10	S5028		

from leaving but then went to get phone to call facility operator E and resident went out the door in wheelchair. Certified staff G met resident in driveway and resident resisted when certified staff G attempted to assist resident back into facility. Resident stood up from wheelchair and fell forward causing injury to face, right forearm, and abrasions to knees. Resident was transported by ambulance to hospital emergency department for evaluation and then returned to facility.

At 3:30 p.m. on 6/13/17, operator E provided the facility investigation of the incident and stated the investigation was just completed and he/she had not sent the report to the department.

The facility investigation included the following:

"Statement of Witness for Incident" with name of certified staff G as person completing the document and dated of 5/23/17. Certified staff G documented that before resident left facility at 1:00 a.m. resident had been denied extra fluids because of "restricted time on care plan" and had been denied exit through front door. Certified staff G offered to allow resident to go sit on the back patio. Resident went to room and came back with jacket and a hat and proceeded to the front door. Certified staff G explained to resident that he/she could not go outside and tried to wheel resident back into the house "but (resident) was forceful and resistant to my help." Certified G went to phone to call facility operator and went back to resident. "Resident fell out of wheelchair when trying to stop elopement." Certified staff G assisted resident back into wheelchair and resident refused first aid by certified staff G. Certified staff G documented the facility operator arrived at 1:30 a.m. and he/she was instructed by on-call nurse by phone to call 911.

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S5028	Continued From page 11 Certified staff G also completed a fall incident report and documented resident fell when resident was moving forward in wheelchair and certified staff was trying to bring resident back to facility. Certified staff G documented incident occurred because resident did not get extra fluids and access out the front door. Licensed nurse B completed a written witness statement documenting receiving a phone call from certified staff G at approximately 1:00 a.m. that resident had been stopped from going out front door but when staff member went to get phone resident went through front door, down the wheelchair ramp and to the driveway. Certified staff G went to the resident and attempted to assist resident back to facility but resident resisted, stood up from wheelchair, and fell forward causing injury to face, right forearm, and abrasions to bilateral knees. Emergency medical services arrived and transported resident to hospital for evaluation. Resident returned with elastic compression wrap to right forearm, noted bruising and abrasions to face, forehead, and across cheeks and chin. Upon return to facility resident was upset with nursing staff, became increasingly agitated, pushing staff and yelling cuss words. Resident later calmed and returned to baseline condition. Licensed nurse B documented a corrective action of employee working at the time of incident was terminated. Visual check of resident every 5 to 30 minutes and staff will continue to monitor resident and resident's whereabouts at all times. The incident involving resident t#6 occurred on 5/23/17 and operator did not report to the department until 5/31/17. Operator did not	S5028		

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S5028	Continued From page 12 complete the investigation report and submit the report to the department until 6/13/17. The report did not include a thorough investigation into why the resident was upset and wanting to leave the facility. The operator failed to report an allegation of potential abuse and/or neglect involving resident #6 to the department within 24 hours of the incident, failed to conduct a thorough investigation within 5 working days, and failed to submit the completed investigation report to the department within 5 working days of the initial report.	S5028		
S5205 SS=F	26-42-104 (a) Disaster and Emergency Preparedness a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(a) The facility reported a census of 5 residents. The sample included 2 residents and 1 closed record reviewed. Based on record review, interview, and observation for all residents, the operator failed to 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. Findings included:	S5205		

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S5205	Continued From page 13 - Resident roster listed 5 residents living in the facility and each resident experienced impaired cognition. At 12:40 p.m. on 6/13/17, observed 2 certified employees on duty to care for the residents. During time in the facility on 6/13/17, observed residents #1, #2, and #4 required physical assistance with ambulation, resident #3 required redirection when ambulating by self with walker, and resident #5 independent with ambulation. At 3:57 p.m. on 6/13/17, certified staff C stated 1 certified staff person worked 6:00 a.m. until 2:00 p.m. and a second certified staff member worked from 10:00 a.m. to 3:00 p.m. Certified staff D was still at work at this time and stated he/she was scheduled to leave at 3:00 p.m. but stayed at work longer if needed for resident care. Certified staff C stated 1 certified staff person worked the 2:00 p.m. to 10:00 p.m. shift and 1 certified staff person worked the 10:00 p.m. to 6:00 a.m. shift. Certified staff C confirmed only 1 certified staff on duty from 3:00 p.m. until 10:00 a.m. the next day. Certified staff C and certified staff D each stated they had not participated in an emergency drill with one person taking all residents to a safe place. At 4:45 p.m. operator E stated he/she had not conducted a drill with one certified staff member evacuating all residents to a safe place. Operator E confirmed only 1 certified staff on duty from 3:00 p.m. to 10:00 a.m. the next day. At 4:17 p.m. on 6/14/17, operator E provided documentation of an emergency drill with evacuation of residents on 1/12/17 and 6/3/17 with 8 employees participating in each drill. The	S5205		

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	B087216	A. BUILDING: _____ B. WING _____	06/19/2017

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S5205	Continued From page 14 documentation of the drill 1/12/17 included 4 residents evacuated and on 6/3/17 listed 3 residents participating. During a phone interview at 4:24 p.m. on 6/14/17, licensed nurse F stated emergency drills with evacuation of resident were conducted during staff meetings with all employees participating in the drill. Licensed nurse F stated he/she had not conducted a drill with 1 certified employee evacuating residents to a safe place. For all residents, the operator failed to demonstrate that one certified employee could safely take residents who would require assistance in an emergency or disaster to a secure location.	S5205		
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 5 residents. The sample included 2 residents and 1 closed record reviewed. Based on record review and interview for 1 (#6) of 1 closed record reviewed and 1 (#1) of 2 residents sampled, the licensed nurse failed to ensure resident records contained documentation of all incidents, symptoms, and	S5251		

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S5251	Continued From page 15 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 #6 revealed an admission date of 8/31/16 and diagnoses of cerebrovascular accident and type 2 diabetes mellitus.. Functional capacity screen dated 12/28/16 indicated resident did not have impaired cognition and was independent with mobility in wheelchair; required supervision with transferring; physical assistance with bathing, dressing, and toileting; was at risk for falls; exhibited socially inappropriate behaviors; and resident's speech was sometimes understandable. Negotiated service agreement/health care service plan dated 12/28/16 documented staff members to supervise resident with transferring, independent with mobility with wheelchair, monitor and report behaviors, resident to call for assistance due to risk for falls, no added salt diet, may have whatever sweets (resident) wants, and limited fluids after 8:00 p.m. Negotiated service agreement/health care service plan documented resident communicated by using hand gestures, shaking/nodding head, and occasional grunting sound. Interdisciplinary progress notes contained documentation by licensed nurse B as follows: 5/5/17 (no time entry documented) medical care provider to see resident. Discussed resident's behavior of sneaking into kitchen and taking snacks and increased blood sugar readings.	S5251		

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S5251	Continued From page 16 Medical care provider increased Glipizide (oral medication to control blood sugar) to two times a day and started Risperdal (antipsychotic) 0.5 milligram daily. Will continue to monitor. Record lacked follow-up nursing assessment of resident's response to increase in Glipizide and addition of Risperdal. 5/23/17 (no time of entry documented) certified staff G called the nurse to report resident at approximately 1:00 a.m. went to front door of facility and attempted to leave. Certified staff G met resident at door in attempt to stop resident from leaving but then went to get phone to call facility operator E and resident went out the door in wheelchair. Certified staff G met resident in driveway and resident resisted when certified staff G attempted to assist resident back into facility. Resident stood up from wheelchair and fell forward causing injury to face, right forearm, and abrasions to knees. Resident was transported by ambulance to hospital emergency department for evaluation and then returned to facility. Ace (elastic compression) wrap to right forearm, bruising and swelling with abrasions noted to face, forehead and across cheeks and chin. Record lacked a thorough nursing assessment of resident's injuries. 5/23/17 (no time entry documented) certified staff G called to report resident was attempting to elope. Certified staff G able to keep resident from leaving facility. Resident yelling and cussing with staff. (Note: resident is non-verbal) Certified staff G called facility operator who instructed certified staff to call 911. Police officers arrived and stated resident would not be admitted to behavioral health and there was not a valid	S5251		

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S5251	Continued From page 17	S5251		

reason to take resident into custody. Resident saw police officers in facility and calmed down. Geodon (antipsychotic) injection given to resident as ordered. Will continue to monitor.

Record lacked follow-up nursing assessment of resident's response to Geodon injection.

5/25/17 (no time of entry documented) certified staff reported resident was attempting to elope from facility. Resident redirected back to his/her room. Doors are locked and resident unaware of code for entry.

5/25/17 (no time entry documented) certified staff reported resident attempted to elope from facility. Resident unable to escape facility due to locks and alarms in place. Episode occurred immediately after dinner. Resident redirected to room without further incident.

During an interview at 10:35 a.m. on 6/14/17, licensed nurse B confirmed he she did not document time on entries in the interdisciplinary notes and a complete assessment of resident's injuries.

The licensed nurse failed to ensure the record for resident #6 contained documentation of all incidents, symptoms, and other indications of injury including the date, time of occurrence, action taken, and results of the action.

- Record review for resident #1 revealed an admission date of 6/5/17 and diagnosis of congestive heart failure.

Functional capacity screen dated 6/5/17 indicated resident was unable to perform bathing, dressing, toileting, transferring, mobility, and management

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S5251	Continued From page 18 of medications and treatments; required physical assistance with eating; experienced impaired cognition; at risk for falls; sometimes resident's communication understandable; and resident rarely understood what was being communicated to him/her. Negotiated service agreement/health care service plan documented facility staff to provide physical assistance with all activities of daily living and administration of medications and treatments. Review of the June 2017 medication administration record (MAR) revealed resident to receive alprazolam (antianxiety) 0.25 milligrams by mouth three times a day as needed for anxiety. The MAR contained documentation by certified medication aides H and J that resident received this medication at 8:00 a.m. on June 7, 8, 9, 10, 11, 12, 2017 for "agitation." Resident's record lacked documentation of a licensed nurse assessment and need for resident to receive alprazolam for agitation when medication was ordered as needed to relieve anxiety. The June 2017 MAR documented certified staff J administered Miralax (laxative) 17 grams by mouth to resident as needed for constipation at 12:00 p.m. on 6/12/17 and at 8:00 a.m. on 6/14/17. At 12:10 p.m. on 6/14/17, certified staff H stated he/she called the facility nurse prior to administration of alprazolam and certified staff J stated he/she called facility nurse or resident's hospice nurse prior to administering alprazolam and Miralax. Certified staff H and J confirmed the resident's record lacked documentation of notification of a licensed nurse and licensed nurse assessment prior to administration of alprazolam and Miralax.	S5251		

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S5251	Continued From page 19 The licensed nurse failed to ensure record for resident #1 contained documentation of all symptoms and other indications of illness including the date, time of occurrence, action taken, and results of the action.	S5251		