| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | B087196 | A. BUILDING: _____ B. WING _____ | 01/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEACE OF MIND LLC II | 223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206 |

| (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<br><br>The following citations represent the findings of an abbreviated survey with investigation of complaint #106441 of the above home plus facility on 1/18/17 and 1/19/17. | S 000 | | |
| S5127 SS=D | 26-42-202 (i) NSA Services Received<br><br>(i) Each administrator or operator shall ensure that each resident receives services according to the provisions of that resident ' s negotiated service agreement.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-202(i)<br><br>The facility reported a census of 5 residents. The sample included 4 residents and 2 closed records reviewed. Based on record review, observation, and interview for 1 (#200) of 4 residents sampled, the operator failed to ensure the resident received a mechanically altered diet according to the resident's negotiated service agreement.<br><br>Findings included:<br><br>- Record review for resident #200 revealed an admission date of 11/3/16 and diagnoses of dementia with behaviors, diabetes, stroke, and coronary artery disease.<br><br>Functional capacity screen dated 11/4/16 indicated resident required staff supervision when eating.<br><br>Negotiated service agreement dated 11/4/16 | S5127 | | |

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 |
|---|---|---|---|
| | B087196 | A. BUILDING: _____ B. WING _____ | 01/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEACE OF MIND LLC II | 223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206 |

| (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 |
|---|---|---|---|---|
| S5127 | Continued From page 1 | S5127 | | |

documented the service of "Mechanical soft 11/22/16" under the food service section.

Record contained written hospital discharge order dated 11/21/16 for a regular mechanical soft diet. Resident hospitalized 11/16/16 with diagnoses of hyperkalemia and renal failure.

Nurse's notes contained an entry by a licensed nurse on 11/21/16 of resident's return from hospital stay with an order for a mechanical soft diet and thin liquids.

At 11:52 a.m. on 1/18/17, certified staff B stated lunch menu of brisket, cabbage, and cornbread.

At 11:58 a.m. on 1/18/17, observed certified staff B prepare a plate with brisket and cabbage that had been prepared in a slow cooker and cornbread. The meat was in long stringy pieces and not cut up into small bite size pieces. Certified staff B took this plate of food and served to resident #200 who sat at the table in the dining room. Observed resident #200 take a bite of cornbread and then took a bite of brisket and cabbage.

At 12:02 p.m. on 1/18/17, certified staff B stated (resident #200) was to receive a mechanical soft diet but could have the food served today because (resident) "does OK with it." Certified staff B stated he/she did not serve meals to resident with food texture altered.

During an interview at 3:50 p.m. on 1/18/17, hospice nurse E stated resident began having trouble with swallowing and had choking episodes while hospitalized as reason resident required a mechanical soft diet.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | B087196 | A. BUILDING: _____ B. WING _____ | 01/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEACE OF MIND LLC II | 223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206 |

| (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 |
|---|---|---|---|---|
| S5127 | Continued From page 2<br>The operator failed to ensure resident #200 received a mechanically altered diet according to the resident's negotiated service agreement. | S5127 | | |
| S5185 SS=E | 26-42-206 (a) (b) (c) Dietary Services<br>(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.<br>(b) The supervisory responsibility for dietetic services shall be assigned to one employee.<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-206(c)<br><br>The facility reported a census of 5 residents. The sample included 4 residents and 2 closed records reviewed. Based on record review, observation, and interview for 2 (#200 and #100) of 4 residents sampled, the operator failed to ensure resident received a mechanically altered diet (resident #200) and thickened liquids (resident #100) prepared according to instructions from a medical care provider or licensed dietitian. | S5185 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | B087196 | A. BUILDING: _____ B. WING _____ | 01/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEACE OF MIND LLC II | 223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206 |

| (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 3<br>Findings included:<br><br>- Record review for resident #200 revealed an admission date of 11/3/16 and diagnoses of dementia with behaviors, diabetes, stroke, and coronary artery disease.<br><br>Functional capacity screen dated 11/4/16 indicated resident required staff supervision when eating.<br><br>Negotiated service agreement dated 11/4/16 documented the service of "Mechanical soft 11/22/16" under the food service section.<br><br>Record contained written hospital discharge order dated 11/21/16 for a regular mechanical soft diet. Resident hospitalized 11/16/16 with diagnoses of hyperkalemia and renal failure.<br><br>Nurse's notes contained an entry by a licensed nurse on 11/21/16 of resident's return from hospital stay with an order for a mechanical soft diet and thin liquids.<br><br>At 11:52 a.m. on 1/18/17, certified staff B stated lunch menu of brisket, cabbage, and cornbread.<br><br>At 11:58 a.m. on 1/18/17, observed certified staff B prepare a plate with brisket and cabbage that had been prepared in a slow cooker and cornbread. The meat was in long stringy pieces and not cut up into small bite size pieces. Certified staff B took this plate of food and served to resident #200 who sat at the table in the dining room. Observed resident #200 take a bite of cornbread and then took a bite of brisket and cabbage.<br><br>Certified staff B stated (resident #200) was to | S5185 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | B087196 | A. BUILDING: _____ B. WING _____ | 01/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEACE OF MIND LLC II | 223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206 |

| (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 4 | S5185 | | |

receive a mechanical soft diet but could have the food served today because (resident) "does OK with it." Certified staff B stated he/she did not grind meat or cut meat into small pieces for resident and did not have written instructions to follow to prepare a mechanically altered diet.

At 12:02 p.m. on 1/18/17, asked operator D for instructions from the medical care provider or licensed dietitian for preparation of a mechanically altered diet.

Operator D provided a notebook labeled "Altered Diets" at 12:22 p.m. on 1/18/17 that included instructions for a mechanical soft diet. These instructions lacked the signature of the medical care provider or a licensed dietitian.

During an interview at 3:50 p.m. on 1/18/17, hospice nurse E stated resident began having trouble with swallowing and had choking episodes while hospitalized as reason resident required a mechanical soft diet.

The operator failed to ensure resident #200 received a mechanically altered diet prepared according to instructions from a medical care provider or licensed dietitian.

- Record review for resident #100 revealed an admission date of 2/5/16 and diagnoses of dysphagia, dementia, and senile degeneration of brain.

Functional capacity screen dated 6/16/16 indicated resident required supervision with eating.

Negotiated service agreement dated 6/16/16 documented resident required nectar thick

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | B087196 | A. BUILDING: _____ B. WING _____ | 01/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEACE OF MIND LLC II | 223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206 |

| (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 5<br>liquids.<br><br>The record contained a signed medical care provider's order dated 7/22/16 for nectar thick liquids.<br><br>At 12:05 p.m. on 1/18/17, observed resident #100 sitting in a wheelchair at the dining table. Observed resident with drinking cup of thickened water.<br><br>During an interview at 3:20 p.m. on 1/18/17, certified staff C stated he/she thickened resident's drinking liquids to nectar thick according to the label instructions on the Thick-it (powder that thickens liquids) container.<br><br>The "Altered Diets" notebook lacked written instructions signed by the medical provider or licensed dietitian for the preparation of nectar thick liquids.<br><br>The operator failed to ensure resident #100 received thickened liquids prepared according to instructions from a medical care provider or licensed dietitian. | S5185 | | |